

Case Number:	CM15-0055441		
Date Assigned:	05/19/2015	Date of Injury:	01/08/2008
Decision Date:	07/07/2015	UR Denial Date:	02/23/2015
Priority:	Standard	Application Received:	03/23/2015

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials: State(s) of Licensure: Georgia
Certification(s)/Specialty: Anesthesiology, Pain Management

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 63 year old male, who sustained an industrial injury on 1/8/08. The injured worker was diagnosed as having cervical facet arthropathy, chronic back pain status post lumbar surgery, lumbar facet arthropathy, lumbar myofascial strain, cervical myofascial strain, lumbar HNP and lumbar spinal stenosis. Treatment to date has included lumbar spine surgery, physical therapy, TENS unit, acupuncture, oral medications including Naproxen, Gabapentin, Nucynta and Oxycodone and epidural injections. Currently, the injured worker complains of chronic back and neck pain described as deep aching, burning with occasional sharp pains, unchanged since previous visit. He rates the pain as 5/10 Physical exam noted moderate tenderness of T10-L5 paraspinals and moderate tenderness of bilateral lumbar paraspinals with severe limited range of motion of lumbar and cervical areas. The treatment plan included a request for authorization for Naproxen, Gabapentin, Oxycodone, Nucynta, and Celebrex, follow up appointment, UDS, spinal cord stimulator trial, psych clearance for spinal cord stimulator trial, physical therapy and (MRI) magnetic resonance imaging of lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Spinal cord stimulator trial: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Indications for stimulator implantation Page(s): 107.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Complex Regional Pain Syndrome Page(s): 32.

Decision rationale: Spinal Cord Stimulator Trial is not medically necessary. Per Ca MTUS spinal cord stimulator recommended only for selected patients in cases when less invasive procedures have failed or are contraindicated, for specific conditions indicated below, and following a successful temporary trial. Although there is limited evidence in favor of Spinal Cord Stimulators (SCS) for Failed Back Surgery Syndrome (FBSS) and Complex Regional Pain Syndrome (CRPS) Type I, more trials are needed to confirm whether SCS is an effective treatment for certain types of chronic pain. Indications for stimulator implantation: Failed back syndrome (persistent pain in patients who have undergone at least one previous back operation), more helpful for lower extremity than low back pain, although both stand to benefit, 40-60% success rate 5 years after surgery. It works best for neuropathic pain. Neurostimulation is generally considered to be ineffective in treating nociceptive pain. The procedure should be employed with more caution in the cervical region than in the thoracic or lumbar. Complex Regional Pain Syndrome (CRPS)/Reflex sympathetic dystrophy (RSD), 70- 90% success rate, at 14 to 41 months after surgery. (Note: This is a controversial diagnosis.), Post amputation pain (phantom limb pain), 68% success rate, Post herpetic neuralgia, 90% success rate Spinal cord injury dysesthesias (pain in lower extremities associated with spinal cord injury) Pain associated with multiple sclerosis, Peripheral vascular disease (insufficient blood flow to the lower extremity, causing pain and placing it at risk for amputation), 80% success at avoiding the need for amputation when the initial implant trial was successful. The data is also very strong for angina. (Flotte, 2004). Additionally, the guidelines indicate that the use of a spinal cord stimulator is a last resort when all other conservative attempts to control the patient's pain have failed, (for example, various medications including neuroleptics for neuropathic pain, injections, physical therapy). There is lack of documentation of a psychological clearance; therefore, the requested service is not medically necessary.

LidoPro Topical ointment: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Non-steroidal anti-inflammatory agents.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

Decision rationale: LidoPro Topical Ointment is not medically necessary. According to California MTUS, 2009, chronic pain, page 111 California MTUS guidelines does not cover "topical analgesics that are largely experimental in use with a few randomized controlled trials to determine efficacy or safety. Any compounded product that contains at least one drug or drug class that is not recommended, is not recommended." Additionally, Per CA MTUS page 111 states that topical analgesics are "Recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy." (anti-depressants or AED). Only FDA-approved products are currently recommended. Non-neuropathic pain: Not recommended. The claimant was not diagnosed with neuropathic pain and there is no documentation of physical findings or diagnostic imaging confirming the diagnosis; therefore, the requested medication is not medically necessary.

Oxycodone 5mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 79.

Decision rationale: Oxycodone is not medically necessary. Per MTUS Page 79 of MTUS guidelines states that weaning of opioids are recommended if; (a) There are no overall improvement in function, unless there are extenuating circumstances. (b) Continuing pain with evidence of intolerable adverse effects. (c) Decrease in functioning. (d) Resolution of pain. (e) If serious non-adherence is occurring. (f) The patient requests discontinuing. The claimant's medical records did not document that there was an overall improvement in function or a return to work with previous opioid therapy. The claimant has long-term use with this medication and there was a lack of improved function with this opioid; Therefore the requested medication is not medically necessary.

Naproxen Sodium 550mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non-steroidal anti-inflammatory drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67.

Decision rationale: Naproxen Sodium 550mg #60 is not medically necessary. Per MTUS guidelines page 67, NSAIDS are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain so to prevent or lower the risk of complications associate with cardiovascular disease and gastrointestinal distress. The medical records do no document the length of time the claimant has been on Anaprox. Additionally, the claimant had previous use of NSAIDs. The medication is therefore not medically necessary.

Physical Therapy 3x per week, for lumbar spine (duration not indicated): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines Treatment in Workers' Compensation (ODG-TWC), Neck & Upper Back Procedure Summary.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99.

Decision rationale: Physical Therapy 3x per weeks, for lumbar spine (duration not indicated) is not medically necessary. Page 99 of Ca MTUS states " physical therapy should allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home physical medicine. For myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks, neuralgia, neuritis, and radiculitis, unspecified (ICD-9 729.2) 8-10 visits over 4 weeks is recommended. The claimant's medical records indicated that he had prior physical therapy visits without documented benefit. Additionally, there is lack of documentation that the claimant participated in active self-directed home physical medicine to maximize his benefit with physical therapy; therefore, the requested service is not medically necessary.