MAXIMUS Federal Services

| Case Number: | CM13-0068679 | | |
|---|---|---|---|
| Date Assigned: | 01/03/2014 | Date of Injury: | 04/12/2002 |
| Decision Date: | 08/05/2014 | UR Denial Date: | 11/26/2013 |
| Priority: | Standard | Application Received: | 12/19/2013 |

## 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

## 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 patient is a 61-year-old male with a 4/12/2002 date of injury. He is status post lumbar decompression, L4-5. [redacted] follows him and pain management for chronic back pain, failed back surgery syndrome. According to the primary treating physician progress report dated 11/05/2012, the patient reported ongoing neck and back complaints, pain rated 6-9/10 on pain scale. He continued pain management with [redacted]. The physical examination findings are unchanged. A handwritten PR-2 signed by [redacted], lists exam dates 7/26 through 12/4/2012 (16 dates listed), states patient had intense to severe back pain that caused depressive and anxiety symptoms. Reported pain level of up to 9 on daily pain scale. The report does not provide any specific objective findings. Only states major depressive disorder, patient has chronic and intense pain, which exacerbates depression; pain not fully addressed by medical doctor; awaiting further treatment. Diagnoses are pain disorder associated with psychological factors and a medical condition; Major depressive disorder. The treatment plan was cognitive behavioral therapy, pain management therapy and progressive relaxation. The physiologist states the patient is an excellent candidate for spinal stimulatory trial. His work status is work for 12 months from DOS: 12/4/2012. The patient had an AME re-examination with [redacted] on 2/4/2013. He previously evaluated the patient on 1/12/2012. According to the AME, the patient had been rendered P&S on 5/16/2007, and there had been no measurable change in the patient's condition since he was declared P&S. His WPI is lumbar spine 15% and he was precluded from heavy lifting, repeated bending and very heavy lifting. The AME recommended the patient have a thoracic MRI. However, he did not believe the patient required any further surgery, and stated his condition would be managed conservatively; he was also not a candidate for additional injections. The AME noted that neurology examination by [redacted] on 10/11/2012 documented the patient had failed back pain syndrome with no evidence of recurrent or other abnormality. The T12-L1 disc was asymptomatic, and noted the cervical MRI was negative. The patient continued to report pain in the lower spine that extended to the legs,

also pain at the thoracolumbar junction and between the shoulder blades. He reported difficulty sleeping and performing activities that involved bending, twisting, lifting/carrying, or weight bearing for prolonged periods of time. On physical examination, the patient was noted to walk slowly with a cane in his left hand (although he is able to walk without it), and otherwise did not demonstrate any evidence of pain behavior. Examination of the thoracic spine reveals some pain in the thoracic area and that the thoracolumbar junction, there was no indurations of muscle spasm, thoracic dermatomal sensory was normal. Lumbar exam revealed well-healed surgical scar, tenderness, report of hypoesthesia in the L5 dermatomes bilaterally, left greater than right, normal muscle strength and deep tendon reflexes, SLR, laseque and femoral stretch are all negative, hip ROM is full and pain-free, he is able to briefly heel/toe walk although this increased his back pain. Radiographs of lumbar taken on date of exam revealed early disc space narrowing; L5-S1 with moderate facet arthrosis, early-moderate disc space narrowing T12-L1 and L1-L2, there is no spondylosis or spondylolisthesis. 6/11/2012 cervical x-rays show mild cervical spondylosis. Lumbar spine MRI 05/31/2012 shows stable changes at the thoracolumbar junction. The impressions 1: S/p lumbar decompressive surgery, L4-5, 2. Thoracic chronic thoracic and lumbar pain-no evidence of radiculopathy. According to the primary treating physician progress report dated 4/04/2013, the patient reported ongoing neck and back complaints, pain rated 7-8/10 on pain scale. He reported he was only authorized #100 MS Contin instead of #120, and he ran out. He took Norco, which he had left over. It is unclear from where he still had Norco and how many he took, since the medical records indicate, he had not been on Norco at least prior to 09/21/2012, when a UDS detected morphine and hydromorphone, and did not detect hydrocodone, which was consistent with prescribed medications. Physical examination findings are unchanged. The thoracic MRI 4/4/2013 reportedly reveal 1) stable central disc protrusion at T 11-T12. 2) The examination otherwise normal limits for aging unchanged. According to the primary treating progress report dated 08/06/2013, the patient presented for follow-up regarding low back pain lower extremity numbness and tingling, which he rated 9/10 on pain scale. The reasons for the last visit. He continues to report numbers and tingling, numbness, and pain extending into his feet. He continues medications and denies any side effects use. A physical examination, which remains unchanged from prior assessments, documented antalgic gait, trembling in the bilateral upper extremities, tenderness to palpation of the sample, thoracic and lumbar paraspinal, decreased range of motion in all planes, decreased sensation to the left, C5, C6 and C7 dermatomes, and left L5 and S1 dermatomes, 5-/5 bilateral psoas and quadriceps, 4+/5 bilateral hamstrings, 5-/5 bilateral TA and left EHL, and the remainder 5/5, straight leg raise bilaterally reproduces pain to the foot. A procedure report dated 10/10/2013 demonstrates the patient was implanted with trial spinal cord stimulator, for diagnosis of failed low back syndrome. According to the primary treating progress report dated 10/23/2013, the patient presented for follow-up regarding low back pain lower extremity numbness and tingling, which he rated 7/10 on pain scale. The patient reported the spinal cord stimulator trial was removed on 10/15/2013. The device decreased his back pain from 9/10 to 7/10, with report of significant decrease in lower extremity paresthesias. The medication that the patient use are MS Contin 15 mg, 4 times per day, gabapentin 800 mg 3 times a day, lidopro cream as topical pain reliever, and docuprene for opioid induced constipation. Physical examination documented, which remains unchanged from prior assessments, antalgic gait, cervical and lumbar paraspinals tender to palpation with muscle spasms, decreased cervical and lumbar range of motion,

decreased sensation on the left L4, L5 and S1 dermatomes, 5-/5 on left deltoid, biceps, wrist extensors and flexion, 5-/5 for bilateral TA, inversion and eversion, 4+/5 bilateral EHL, and straight leg raise is positive bilaterally and 60. Diagnoses are 1. Failed low back surgery syndrome; 2. Moderate to severe lumbar stenosis, worse at L4-L5, 3. Ongoing internal medicine issues regarding diabetes mellitus, hypertension, and essential tremor; 4. T12-L1 spinal cord compression with conus compression; 5. Stable and mildly elevated liver enzymes; 6. Chronic pain syndrome. The request is made for permanent cord stimulator placement.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**PERMANENT SPINAL CORD STIMULATOR:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Spinal cord stimulators (SCS) Page(s): 105-107. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Spinal cord stimulators (SCS).

**Decision rationale:** According to the guidelines, SCS is recommended only for selected patients in cases when less invasive procedures have failed or are contraindicated. There is limited evidence in favor of Spinal Cord Stimulators (SCS) for Failed Back Surgery Syndrome. The guidelines state an indication for SCS is 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 ineffective in treating nociceptive pain. In this case, the patient underwent a 5-day SCS trial on 10/10 to 10/15/2013. The patient reported the device reduced his pain from 9/10 to 7/10. This does not represent any significant reduction in pain. In addition, the medical records do not establish there had been significant reduction in medication use and objective increase in function. The patient's physical examination findings had remained unchanged. In addition, it is also noted that according to the 2/4/2013 AME report of [redacted], the patient is not a candidate for any further surgery. His condition should be managed conservatively. The medical records does not establish permanent implantation of SCS is appropriate and medically necessary. The request is not medically necessary.

**MS CONTIN 15MG #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 81.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, specific drug list, criteria for use Page(s): 78, 93.

**Decision rationale:** Morphine sulfate, Morphine sulfate ER, CR (Avinza; Kadiam; MS Contin; Oramorph SR; generic available, except extended release capsules): Side Effects: See opioid adverseeffects. Analgesic dose: Controlled, extended and sustained release preparations should be reserved for patients with chronic pain, who are need of continuous treatment. 4) On-Going Management. (d) Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain dairy that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management. (g) Continuing review of overall situation with regard to non-opioid means of pain control. 6) When to Discontinue Opioids: (a) If there is no overall improvement in function, unless there are extenuating Circumstances. 7) When to Continue Opioids: (a) If the patient has returned to work; (b) If the patient has improved functioning and pain. Long-acting opioids: Also known as, controlled-release, extended-release, sustained-release or long-acting opioids are a highly potent form of opiate analgesic. The proposed advantage of long-acting opioids is that they stabilize medication levels, and provide around-the-clock analgesia. Long-acting opioids include Morphine (MS Contin, Oramorph SR, Kadian, Avinza), Oxycodone (Oxycontin), Fentanyl (Duragesic Patch), Hydromorphone (Palladone). Ongoing management should include ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The medical records do not establish that this patient requires long-acting opioids. In the case of this patient, review of the medical records from November 2012 to October 2013 do not reveal any indication that use of MS Contin has provided a notable improvement in pain level or function. It is interesting that when provided he was seen on 4/4/2013, and he reported having run out of MS Contin because he was authorized #100 instead of #120, and had run out, his reported pain level was 7-8/10, slightly better than in the subsequent months when he continued report of 9/10 pain level. In fact, he has reported up to 9/10 pain at least since November 2012. In addition, the documented objective findings have also remained unchanged. There is no evidence that ongoing use of MS Contin has led to any notable improvement in pain and functional levels. In addition, the clinical findings do not support the need for around-the-clock analgesia. Furthermore, there lacks documentation of active and ongoing utilization of non-opioid and non-pharmacologic methods of pain control and improving function. Based on these factors, continuation of MS Contin is not supported by the evidence-based guidelines, and therefore, would not be recommended. Tapering/weaning from opioids is indicated. The request is not medically necessary.