

<b>Case Number:</b>	CM14-0120369		
<b>Date Assigned:</b>	08/06/2014	<b>Date of Injury:</b>	12/07/2005
<b>Decision Date:</b>	10/07/2014	<b>UR Denial Date:</b>	07/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/30/2014

### 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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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 45-year-old female who has submitted a claim for degeneration of lumbar or lumbosacral intervertebral disks, lumbago, lumbar post laminectomy syndrome, chronic lumbosacral radiculopathy, sacroiliitis, lumbar facet joint pain, myalgia, myositis, and hand tenosynovitis associated with an industrial injury date of 12/7/2005. Medical records from 2014 were reviewed. Patient complained of low back pain and bilateral thigh pain. Patient likewise experienced right ulnar pain. Patient had a diagnostic hardware block with good relief of pain for a few weeks. She was interested in hardware removal. She reported constant, alternating burning, tingling pain and numbness of the right hand and forearm. Pain severity was rated 6 to 7/10 with medications. Patient likewise complained of heartburn symptoms. Intake of famotidine provided symptom relief. Physical examination of the lumbar spine showed tenderness and restricted motion. Muscle spasms were noted. Straight leg raise test at the left was positive. Bilateral Patrick's test was positive. Sensation was diminished at right lateral forearm and fourth and fifth digits. Urine drug test from 4/17/2014 showed positive levels for opiates. Treatment to date has included L5 to S1 interbody and intertransverse fusion with instrumentation on 8/2006, lumbar epidural steroid injection in 2010 (provided 70% pain relief for at least 12 weeks) and medications such as Elavil (since 2013), gabapentin, Zanaflex, and oxycodone (since January 2014). Patient reported that intake of medications provided symptom relief and allowed her to perform activities of daily living. Utilization review from 7/1/2014 modified the request for Elavil (quantity unspecified) x 3 refills into #60 for the purpose of weaning because of no documented objective benefit; modified the request for Gabapentin (quantity unspecified) x 3 refills into #90 for the purpose of weaning because of no documented objective benefit; denied Pepcid (quantity unspecified) x 3 refills because it was only recommended for gastrointestinal side effects secondary to NSAID use; denied Zanaflex

(quantity unspecified) x 3 refills because of no evidence of muscle spasm; modified the request for Oxycodone IR 15mg #150 into #90 for the purpose of weaning because of no documented actual daily frequency of use and because of no evidence of substantial change in pain score; denied (L) L5-S1 Transforaminal Epidural Steroid Injection because there was no evidence of radicular symptoms; and denied hardware removal because of no clear indication.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Elavil (quantity unspecified) x 3 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Amitriptyline (Elavil) is a tricyclic antidepressant..

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for Chronic Pain Page(s): 13-14.

**Decision rationale:** As stated on page 14 of CA MTUS Chronic Pain Medical Treatment Guidelines, tricyclic antidepressants, such as amitriptyline and nortriptyline, are recommended as a first-line option for neuropathic pain, especially if pain is accompanied by insomnia, anxiety, or depression. In this case, the patient has been on Elavil since 2013. Patient reported symptom relief from medication use, which allowed her to perform activities of daily living. Clinical manifestations are likewise consistent with neuropathic pain. However, the request failed to specify dosage and quantity to be dispensed. The request is incomplete; therefore, the request for Elavil (quantity unspecified) x 3 refills is not medically necessary.

**Gabapentin (quantity unspecified) x 3 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Neurontin is an anti-epilepsy drug. Page(s): 49.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drugs Page(s): 16-17.

**Decision rationale:** As stated on pages 16 - 17 of CA MTUS Chronic Pain Medical Treatment Guidelines, antidepressants, such as pregabalin and gabapentin, are recommended as a first line option for neuropathic pain, i.e., painful polyneuropathy. In this case, the patient has been on gabapentin since January 2014. Patient reported symptom relief from medication use, which allowed her to perform activities of daily living. Clinical manifestations are likewise consistent with neuropathic pain. However, the request failed to specify dosage and quantity to be dispensed. The request is incomplete; therefore, the request for Gabapentin (quantity unspecified) x 3 refills is not medically necessary.

**Pepcid (quantity unspecified) x 3 refills:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation [www.webmd.com/drugs](http://www.webmd.com/drugs) :Famotidine (Pepcid)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: FDA (Famotidine)

**Decision rationale:** The CA MTUS does not specifically address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers Compensation, the Food and Drug Administration was used instead. The FDA states that famotidine is an H2 receptor antagonist indicated in the treatment of active gastric or duodenal ulcers, or for endoscopically diagnosed erosive esophagitis. In this case, patient has been on Pepcid since January 2014. Patient reported that heartburn symptoms, relieved upon intake of famotidine. The medical necessity for continuing management has been established. However, the request failed to specify dosage and quantity to be dispensed. The request is incomplete; therefore, the request for Pepcid (quantity unspecified) x 3 refills is not medically necessary.

**Zanaflex (quantity unspecified) x 3 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63,66.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxant Page(s): 63.

**Decision rationale:** According to page 63 of the CA MTUS Chronic Pain Medical Treatment Guidelines, non-sedating muscle relaxants are recommended with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. In this case, the patient has been on Zanaflex since January 2014. Patient reported symptom relief from medication use, allowing her to perform activities of daily living. The most recent physical examination still showed evidence of muscle spasm. However, long-term use of muscle relaxant is not recommended. The requested likewise failed to specify dosage and quantity to be dispensed. The request is incomplete; therefore, the request for Zanaflex (quantity unspecified) x 3 refills is not medically necessary.

**Oxycodone IR 15mg #150:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines On-going opioid use: On-Going Management..

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

**Decision rationale:** As stated on page 78 of CA MTUS Chronic Pain Medical Treatment Guidelines, there are 4 A's for ongoing monitoring of opioid use: pain relief, side effects,

physical and psychosocial functioning and the occurrence of any potentially aberrant drug-related behaviors. The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. In this case, the patient has been on oxycodone since January 2014. Patient reported symptom relief from medication use, allowing her to perform activities of daily living. Urine drug test from 4/17/2014 likewise showed positive levels for opiates. Guideline criteria for continuing opioid management have been met. Therefore, the request for Oxycodone IR 15mg #150 is medically necessary.

**(L) L5-S1 Transforaminal Epidural Steroid Injection: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ESI injections Page(s): 46.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection Page(s): 46.

**Decision rationale:** As stated on page 46 of CA MTUS Chronic Pain Medical Treatment Guidelines, epidural steroid injection (ESI) is indicated among patients with radicular pain that has been unresponsive to initial conservative treatment. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks. In this case, patient complained of low back pain and bilateral thigh pain. Physical examination of the lumbar spine showed tenderness and restricted motion. Straight leg raise test at the left was positive. Bilateral Patrick's test was positive. Patient underwent lumbar epidural steroid injection in 2010 resulting to 70% pain relief for at least 12 weeks. However, clinical manifestations were not consistent with radiculopathy. Moreover, there was no imaging result or electrodiagnostic study presented in the medical records. The medical necessity cannot be established due to insufficient information. Guideline criteria were not met. Therefore, the request for (L) L5-S1 Transforaminal Epidural Steroid Injection is not medically necessary.

**Hardware Removal: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines:Hardware removal (fixation)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Section, Hardware Implant Removal (Fixation)

**Decision rationale:** The CA MTUS does not specifically address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers Compensation, the Official Disability Guidelines (ODG) was used instead. ODG states that routine removal of hardware implanted for fixation is not recommended, except in the case

of broken hardware or persistent pain, after ruling out other causes of pain such as infection and nonunion. Implant removal in symptomatic patients is rated to be moderately effective. In this case, patient underwent L5 to S1 interbody and intertransverse fusion with instrumentation on 8/2006. Patient complained of persistent low back pain and bilateral thigh pain. Physical examination of the lumbar spine showed tenderness and restricted motion. Straight leg raise test at the left was positive. Bilateral Patrick's test was positive. Patient had a diagnostic hardware block with good relief of pain for a few weeks; hence, this request for hardware removal. However, other possible causes of pain etiology have yet to be ruled out. A comprehensive physical examination was also not available for review. No imaging study was likewise included in the records submitted. The medical necessity cannot be established due to insufficient information. Therefore, the request for **HARDWARE REMOVAL** is not medically necessary.