

Case Number:	CM14-0147256		
Date Assigned:	09/15/2014	Date of Injury:	10/28/2005
Decision Date:	10/15/2014	UR Denial Date:	08/22/2014
Priority:	Standard	Application Received:	09/10/2014

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 Family 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:

This is a female patient who reported an industrial injury to the back on 10/28/2005, nine (9) years ago, attributed to the performance of her usual and customary job tasks. The patient continues to complain of lower back pain. The patient was noted to have had a right sided SI joint injection on July 8, 2014. The SI injection resulted in no sustained functional improvement. Subsequent to that injection, the treating physician ordered bilateral SI corticosteroid injections. The patient has been prescribed Norco 10/325 mg #60; Flexeril 10 mg #60; Neurontin 300 mg #90; and Ambien 10 mg #30 The diagnosis was chronic lumbar sprain/strain; unspecified back disorder; and acquired spondylolisthesis.

IMR ISSUES, DECISIONS AND RATIONALES

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

CT guided Bilateral SI Joint Injection: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines; Work Loss Data Institute, LLC; Corpus Christi, TX; www.odg-twc.com; Section: Hip & Pelvis (Acute & Chronic) (updated 03/25/2014)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip and Pelvis chapter--SI joint blocks

Decision rationale: The requesting physician did not provide subjective/objective evidence to support the medical necessity of the requested bilateral SI corticosteroid injections for the treatment of the patient's industrial injury symptoms related to the back over the recommended participation in a self-directed home exercise program. The requested bilateral SI injections are directed to the SI joints nine (9) years after the DOI with no objective findings documented on examination other than simple tenderness to the SI joints. The patient has been treated with opioids for a prolonged period time directed to the diagnosis of lumbar spine DDD and chronic low back pain. The patient has not been treated for SI joint dysfunction in the past and there is no provided nexus supported with objective evidence to the cited mechanism of injury. The patient is only documented to have tenderness to the SI joints along with the reported hip symptoms. The patient was noted to have received bilateral a right SI injection with no sustained functional improvement. The cited diagnoses do not meet the criteria for the requested left SI injection. The patient is not demonstrated to be pursuing a home exercise program for the treatment of the SI joints. There is no rationale how the SI joint arthritis relates to the mechanism of injury. The patient does not meet the criteria of the evidence-based guidelines for the continued treatment on a maintenance basis with corticosteroid injection to the SI joints, sacrospinous ligaments or the piriformis muscles. There is no demonstrated medical necessity for a corticosteroid injection to the SI joint for only tenderness. There is no demonstrated progressive SI changes or demonstrated sacroiliitis on x-rays. The CA MTUS and the ACOEM Guidelines do not specifically address the use of diagnostic SI joint blocks for the evaluation of pain generators. The updated chapter 12 (4/7/08) for back pain in the ACOEM Guidelines do not recommend the use of SI injections for the treatment of chronic lower back pain or for any chronic radiculopathy. The treatment is only recommended for those patients with demonstrated SI arthritic changes and demonstrated Sacroiliitis. It is not clear that the use of maintenance corticosteroid injections for the treatment of SI tenderness or piriformis tenderness demonstrated on examination along with the oral medications prescribed is medically necessary and the requesting provider has not supported the request with objective evidence to support the medical necessity of SI injections. The patient has not been documented to have the minimum of three (3) objective findings recommended by the Official Disability Guidelines. Criteria for the use of sacroiliac blocks:

1. The history and physical should suggest the diagnosis (with documentation of at least 3 positive exam findings: Specific tests for motion palpation and pain provocation have been described for SI joint dysfunction: Cranial Shear Test; Extension Test; Flamingo Test; Fortin Finger Test; Gaenslen's Test; Gillet's Test (One Legged-Stork Test); Patrick's Test (FABER); Pelvic Compression Test; Pelvic Distraction Test; Pelvic Rock Test; Resisted Abduction Test (REAB); Sacroiliac Shear Test; Standing Flexion Test; Seated Flexion Test; Thigh Thrust Test (POSH). Imaging studies are not helpful. It has been questioned as to whether SI joint blocks are the "diagnostic gold standard."
2. Diagnostic evaluation must first address any other possible pain generators.
3. The patient has had and failed at least 4-6 weeks of aggressive conservative therapy including PT, home exercise and medication management.
4. Blocks are performed under fluoroscopy. (Hansen, 2003)
5. A positive diagnostic response is recorded as 80% for the duration of the local anesthetic. If the first block is not positive, a second diagnostic block is not performed.
6. If steroids are injected during the initial injection, the duration of pain relief should be at least 6 weeks with at least > 70% pain relief recorded for this period.
7. In the treatment or therapeutic phase (after the stabilization is completed), the suggested frequency for repeat blocks is 2 months or longer between each injection, provided that at least >70% pain relief is obtained for 6 weeks.
8. The block is not to be performed on the same day as a lumbar epidural steroid injection (ESI),

transforaminal ESI, facet joint injection or medial branch block.

9. In the treatment or therapeutic phase, the interventional procedures should be repeated only as necessary judging by the medical necessity criteria, and these should be limited to maximum of 4 times for local anesthetic and steroid blocks over a period of 1 year. There is no demonstrated medical necessity for the requested bilateral SI joint corticosteroid injections.

PT 2x6: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 79.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299-300, Chronic Pain Treatment Guidelines PHYSICAL MEDICINE Page(s): 97-98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) neck and upper back chapter-PT; back chapter-PT

Decision rationale: The request is for authorization of 2x6 additional sessions of PT to the back nine (9) years after the DOI exceeds the number of sessions of PT recommended by the CA MTUS and the time period recommended for rehabilitation. The evaluation of the patient documented no objective findings on examination to support the medical necessity of physical therapy over the recommended self-directed home exercise program with documented weakness but no muscle atrophy as opposed to a self-directed HEP. There are no objective findings to support the medical necessity of 12 additional sessions of physical therapy for the rehabilitation of the patient over the number recommended by evidence-based guidelines. The patient is noted to have had no functional improvement with recently provided sessions of PT and had previously been discharged from physical therapy due to a lack of progression. The patient is documented with no signs of significant weakness, no significant reduction of ROM, or muscle atrophy.

There is no demonstrated medical necessity for the prescribed PT to the back 9 years after the DOI. The patient is not documented to be in HEP. There is no objective evidence provided by the provider to support the medical necessity of the requested 12 additional sessions of PT over a self-directed home exercise program. The CA MTUS recommends ten (10) sessions of physical therapy over 8 weeks for the lumbar spine rehabilitation subsequent to lumbar/thoracic strain/sprain and lumbar spine DDD with integration into HEP. The provider did not provide any current objective findings to support the medical necessity of additional PT beyond the number recommended by evidence-based guidelines. The request for an additional 26 sessions of physical therapy directed to the back is not demonstrated to be medically necessary.

Norco 10/325mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS Page(s): 74-97. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter-opioids

Decision rationale: The prescription for Hydrocodone-APAP (Norco) 10/325 mg #60 for short acting pain is being prescribed as an opioid analgesic for the treatment of chronic pain to the

back for the date of injury nine (9) years ago. The objective findings on examination do not support the medical necessity for continued opioid analgesics. The patient is being prescribed opioids for chronic mechanical low back pain, which is inconsistent with the recommendations of the CA MTUS. There is no objective evidence provided to support the continued prescription of opioid analgesics for the cited diagnoses and effects of the industrial claim. The patient should be titrated down and off the prescribed Hydrocodone. The patient is nine (9) years s/p DOI with reported continued issues postoperatively; however, there is no rationale supported with objective evidence to continue the use of opioids. There is no demonstrated medical necessity for the continuation of opioids for the effects of the industrial injury. The chronic use of Hydrocodone-APAP/Norco is not recommended by the CA MTUS, the ACOEM Guidelines, or the Official Disability Guidelines for the long-term treatment of chronic back pain. There is no demonstrated sustained functional improvement from the prescribed high dose opioids. The prescription of opiates on a continued long-term basis is inconsistent with the CA MTUS and the Official Disability Guidelines recommendations for the use of opiate medications for the treatment of chronic pain. There is objective evidence that supports the use of opioid analgesics in the treatment of this patient over the use of NSAIDs for the treatment of chronic pain. The current prescription of opioid analgesics is inconsistent with evidence-based guidelines. The prescription of opiates on a continued long-term basis is inconsistent with the Official Disability Guidelines recommendations for the use of opiate medications for the treatment of chronic pain. There is objective evidence that supports the use of opioid analgesics in the treatment of this patient over the use of NSAIDs for the treatment of chronic pain issues. Evidence-based guidelines necessitate documentation that the patient has signed an appropriate pain contract, functional expectations have been agreed to by the clinician, and the patient, pain medications will be provided by one physician only, and the patient agrees to use only those medications recommended or agreed to by the clinician to support the medical necessity of treatment with opioids. The ACOEM Guidelines updated chapter on chronic pain states, "Opiates for the treatment of mechanical and compressive etiologies: rarely beneficial. Chronic pain can have a mixed physiologic etiology of both neuropathic and nociceptive components. In most cases, analgesic treatment should begin with acetaminophen, aspirin, and NSAIDs (as suggested by the WHO step-wise algorithm). When these drugs do not satisfactorily reduce pain, opioids for moderate to moderately severe pain may be added to (not substituted for) the less efficacious drugs. A major concern about the use of opioids for chronic pain is that most randomized controlled trials have been limited to a short-term period (70 days). This leads to a concern about confounding issues; such as, tolerance, opioid-induced hyperalgesia, long-range adverse effects, such as, hypogonadism and/or opioid abuse, and the influence of placebo as a variable for treatment effect." ACOEM guidelines state that opioids appear to be no more effective than safer analgesics for managing most musculoskeletal symptoms; they should be used only if needed for severe pain and only for a short time. The long-term use of opioid medications may be considered in the treatment of chronic musculoskeletal pain, if: The patient has signed an appropriate pain contract; Functional expectations have been agreed to by the clinician and the patient; Pain medications will be provided by one physician only; The patient agrees to use only those medications recommended or agreed to by the clinician. ACOEM also notes, "Pain medications are typically not useful in the subacute and chronic phases and have been shown to be the most important factor impeding recovery of function." There is no clinical documentation by with objective findings on examination to support the medical necessity of Hydrocodone-APAP for this long period of time or to support ongoing functional improvement. There is no provided evidence that the patient has received benefit or demonstrated functional improvement with the prescribed Hydrocodone-APAP. There is no demonstrated medical necessity for the prescribed Opioids. The continued prescription for Norco 10/325 mg #60 is not demonstrated to be medically necessary.

Neurontin 300mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 18-19.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines GABAPENTIN Page(s): 49. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) chronic pain chapter revised 8/8/08 page 110;; Official Disability Guidelines (ODG) pain chapter-medications for chronic pain; anti-epilepsy drugs;

Decision rationale: The provider has prescribed Gabapentin (Neurontin) 300 mg #60 and there is a reported neuropathic pain issue. There is no documented Electrodiagnostic evidence of a nerve impingement radiculopathy. There is no demonstrated neurological deficit along a dermatomal distribution. It is not clear that the patient has neuropathic pain, as there are no documented neurological deficits. The patient is stated to have neuropathic pain for which the patient has been prescribed Gabapentin/Neurontin. The prescription of Gabapentin (Neurontin) was not demonstrated to have been effective for the patient for the chronic pain issues. The provider does not provide objective findings on examination to support the presence of neuropathic pain for the cited diagnoses. The provider has provided this medication for the daily management of this patient's chronic pain. The prescription of Gabapentin (Neurontin) is recommended for neuropathic pain; however, the ACOEM Guidelines. Gabapentin or pregabalin is not recommended for treatment of chronic, non-neuropathic pain by the ACOEM Guidelines. It is clear that there is no documentation of significant neuropathic pain for this patient. The ACOEM Guidelines revised chronic pain chapter states that there is insufficient evidence for the use of Gabapentin or Lyrica for the treatment of axial lower back pain; chronic lower back pain; or chronic lower back pain with radiculopathy. The CA MTUS and the Official Disability Guidelines state that there is insufficient evidence to support the use of Gabapentin or Lyrica for the treatment of chronic axial lower back pain. The prescription of Gabapentin for neuropathic pain was not supported with objective findings on physical examination. There was objective evidence that the recommended conservative treatment with the recommended medications have been provided prior to the prescription of Lyrica for chronic pain. The use of Gabapentin/Lyrica should be for neuropathic pain. Presently, there is documented objective evidence of neuropathic pain for which the use of Gabapentin is recommended. The patient has demonstrated neuropathic pain secondary to a nerve impingement neuropath and the diagnosed CRPS and is demonstrating neuropathic pain for which Gabapentin/Lyrica is recommended. The prescription of Gabapentin is recommended for neuropathic pain and is used to treat postherpetic neuralgia and painful polyneuropathy, such as, diabetic polyneuropathy. Anti-epilepsy drugs (AEDs) are recommended on a trial basis (Lyrica/gabapentin/pregabalin) as a first-line therapy for painful polyneuropathy, such as, diabetic polyneuropathy. The updated chapter of the ACOEM Guidelines does not recommend the use of Lyrica or Gabapentin (Neurontin) for the treatment of axial back pain or back pain with radiculopathy. The use of Neurontin is for neuropathic pain; however, evidence based guidelines do not recommend the prescription of Gabapentin for chronic lower back pain with a subjective or objective radiculopathy and favors alternative treatment. There is no demonstrated medical necessity for the prescribed Neurontin 300 mg #60.

Ambien 10mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 79.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS Page(s): 80-82. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter--insomnia and Zolpidem Other Medical Treatment Guideline or Medical Evidence: Disciplinary Guidelines for the general practice of medicine

Decision rationale: Zolpidem/Ambien 10 mg #30 is recommended only for the short-term treatment of insomnia for two to six weeks. The Zolpidem/Ambien 10 mg has been prescribed to the patient for a prolonged period of time. The use of Zolpidem or any other sleeper has exceeded the ODG guidelines. The prescribing physician does not provide any rationale to support the medical necessity of Zolpidem for insomnia or documented any treatment of insomnia to date. The patient is being prescribed the Zolpidem for insomnia due to chronic back pain simply due to the rationale of chronic pain without demonstrated failure of OTC remedies. There is no provided subjective/objective evidence to support the use of Zolpidem 10 mg over the available OTC remedies. The patient has exceeded the recommended time period for the use of this short-term sleep aid. There is no demonstrated functional improvement with the prescribed Zolpidem/Ambien. There is no documentation of alternatives other than Zolpidem have provided for insomnia or that the patient actually requires sleeping pills. The patient is not documented with objective evidence to have insomnia or a sleep disorder at this point in time or that conservative treatment is not appropriate for treatment. There is no evidence that sleep hygiene, diet and exercise have failed for the treatment of sleep issues. There is no demonstrated failure of the multiple sleep aids available OTC. The CA MTUS and the ACOEM Guidelines are silent on the use of sleeping medications. The ODG does not recommend the use of benzodiazepines in the treatment of chronic pain. Zolpidem is not a true benzodiazepine; however, retains some of the same side effects and is only recommended for occasional use and not for continuous nightly use. There is no medical necessity for the prescribed Zolpidem.