

Case Number:	CM14-0162037		
Date Assigned:	10/07/2014	Date of Injury:	10/19/1992
Decision Date:	11/07/2014	UR Denial Date:	09/17/2014
Priority:	Standard	Application Received:	10/02/2014

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 Occupational 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 claimant was injured on 10/19/92 and she has incomplete paraplegia with chronic pain and use of crutches. A repeat lumbar epidural steroid injection with an L2 paravertebral block, Lyrica, Zanaflex, Nexium, hyoscyamine, and Xanax are under review. She reported on 02/21/14 that she was buying Wellbutrin out-of-pocket and without the Lyrica her pain would be completely unbearable at level 10/10. She had not been able to get Nucynta ER since November. Nucynta took her pain from 8/10 to 4/10. Without the medications her life would not be worth living. She was using urinary incontinence pads every day. Her lesion was described as unresectable. Authorization for spinal cord trial was received according to a note dated 04/18/14. A psychological evaluation was awaited. On 05/09/14, she saw a provider and reportedly had used Percocet for a long term and had never really escalated her medications. She received an IM injection of Toradol, morphine, Valium, and Depo-Medrol. Her pain resolved by about half. She appeared to have worsening neuropathic pain due to her spinal cord injury. She had burned herself and had a decubitus burn ulceration on the left hip. She had paraplegia in the left lower extremity. A spinal cord stimulator trial was awaited. She was given hyoscyamine for spastic bladder. She had a psychological evaluation on 06/04/14. She stated that Lyrica was critical and she was given Lucenta. Wellbutrin helped her anxiety and depression. On 06/11/14, her medications included Percocet, Lyrica, and hyoscyamine and she received IM Toradol and Depo-Medrol. An MRI of the thoracic spine dated 06/27/14 revealed no significant change from the prior study. There were postsurgical changes from a posterior spinal fusion from T10-11 through T12-L1. There were bilateral laminectomy defects. There were no disc herniations, spinal canal stenosis, or neural foraminal stenosis and little change from the prior MRI on 04/18/13. There were some degenerative changes and a posterior disc osteophyte complex at T11-12. An MRI of the lumbar spine revealed multilevel degenerative changes with postop

changes from the fusion. There were multilevel laminectomy defects. There was severe spinal canal stenosis at T11-12. There was also facet arthropathy at several levels. An epidural steroid injection with L2 sympathetic block on 07/23/14 brought her pain down 30-40% in her back and leg. She was quite a bit better and wanted to repeat it. On 09/29/14, she was seen in an emergency department and complained of headache and increased stress for 3 months. She had been told 3 months before that she had hypertension and her blood pressure was elevated and she was sent to the emergency department. She also had some photophobia, nausea, shortness of breath, and mild chest pain for the past 2 weeks. Blood pressure was 143/92. On 09/30/14, she was evaluated and stated her blood pressure was 240/120 at the clinic and she went to the ED. She was given clonidine. She was diagnosed with uncontrolled hypertension. A CT scan of the brain was unremarkable. She has received companion care on multiple dates. She was approved for a spinal cord stimulator trial. A repeat ESI with an L2 paravertebral was recommended.

IMR ISSUES, DECISIONS AND RATIONALES

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

Xanax 0.5 mg # 60: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 54.

Decision rationale: The history and documentation do not objectively support the request for Xanax 0.5 mg #60. The MTUS state "benzodiazepines (alprazolam) are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. A more appropriate treatment for anxiety disorder is an antidepressant. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks." In this case, the claimant's pattern of use of Xanax is unknown and the anticipated measurable objective benefit to her has not been described. The indications for its use in this case are unknown and none can be ascertained from the records. The medical necessity of this request for Xanax 0.5 mg #60 has not been clearly demonstrated.

Lyrica 150 mg # 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lyrica, Page(s): 131,46.

Decision rationale: The MTUS state "pregabalin (Lyrica) has been documented to be effective in treatment of diabetic neuropathy and postherpetic neuralgia, has FDA approval for both indications, and is considered first-line treatment for both. Pregabalin was also approved to treat fibromyalgia.... Anti-epilepsy drugs (AEDs) are also referred to as anti-convulsants. [They are] recommended for neuropathic pain (pain due to nerve damage). (Gilron, 2006) (Wolfe, 2004) (Washington, 2005) (ICSI, 2005) (Wiffen-Cochrane, 2005) (Attal, 2006) (Wiffen-Cochrane, 2007) (Gilron, 2007) (ICSI, 2007) (Finnerup, 2007) There is a lack of expert consensus on the treatment of neuropathic pain in general due to heterogeneous etiologies, symptoms, physical signs and mechanisms. Most randomized controlled trials (RCTs) for the use of this class of medication for neuropathic pain have been directed at postherpetic neuralgia and painful polyneuropathy (with diabetic polyneuropathy being the most common example). There are few RCTs directed at central pain and none for painful radiculopathy. (Attal, 2006) The choice of specific agent [including pregabalin] will depend on the balance between effectiveness and adverse reactions." In this case, there is no evidence of any of the diagnoses above that may be causing neuropathic pain, including diabetic neuropathy, postherpetic neuralgia, fibromyalgia, or radiculopathy. There are no focal symptoms of neuropathic and no studies have been done to evaluate the effectiveness of Lyrica for radiculopathic pain. The medical necessity of the use of Lyrica 150mg, #60 has not been demonstrated.

Zanaflex 2 mg # 90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxers Page(s): 97.

Decision rationale: The history and documentation do not objectively support the request for the use of Zanaflex 2 mg, #90. The MTUS state "muscle relaxants (for pain): Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. (Chou, 2007) (Mens, 2005) (Van Tulder, 1998) (van Tulder, 2003) (van Tulder, 2006) (Schnitzer, 2004) (See, 2008) Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. (Homik, 2004) Sedation is the most commonly reported adverse effect of muscle relaxant medications." Additionally, MTUS state "relief of pain with the use of medications is generally temporary and measures of the lasting benefit from this modality should include evaluating the effect of pain relief in relationship to improvements in function and increased activity. Before prescribing any medication for pain, the following should occur: (1) determine the aim of use of the medication; (2) determine the potential benefits and adverse effects; (3) determine the patient's preference. Only one medication to be given at a time, and interventions that are active and passive should remain unchanged at the time of the medication change. A trial should be given for each individual medication. Analgesic medication should show effects within 1 to 3 days, ... A record of pain and function with the medication should be recorded. (Mens 2005)" The medical

documentation provided does not establish the need for long-term/chronic usage of Zanaflex which MTUS guidelines advise against. Additionally, the medical records provided do not provide objective findings of acute spasms or a diagnosis of acute spasm. In this case, the claimant's pattern of use of medications, including other first-line drugs such as acetaminophen and anti-inflammatories and the response to them, and her response to her exercises, including relief of symptoms and documentation of functional improvement, have not been described. As such, this request for Zanaflex 2 mg #90 is not medically necessary.

Nexium 40 mg # 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MCN, Proton Pump Inhibitors Page(s): 68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Proton Pump Inhibitors, Page(s): 102. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Formulary - Nexium

Decision rationale: The history and documentation do not objectively support the request for Nexium 40 mg, #60. The MTUS state on p. 102 re: PPIs "patients at intermediate risk for gastrointestinal events and no cardiovascular disease: (1) A non-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg omeprazole daily) or misoprostol (200 g four times daily) or (2) a Cox-2 selective agent." The ODG formulary states "a trial of omeprazole or lansoprazole is recommended before Nexium therapy. In this case, there is no clear documentation of any ongoing GI conditions or increased risk to support the use of this medication. The claimant has no documentation of a diagnosis of GERD/reflux and there is no evidence that she received a trial of a first line proton pump inhibitor. Also, there is no current documentation of ongoing gastrointestinal symptoms or findings on examination that warrant the use of this medication. The medical necessity of the use of Nexium 40 mg, #60 has not been demonstrated.

Hyoscyamine 0.375 mg # 60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter

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: PDR, 2014: Hyoscyamine

Decision rationale: The history and documentation support/do not objectively support the request for hyoscyamine 0.375 mg #60. The MTUS and ODG do not address its use. The PDR recommends its use to gastrointestinal symptoms and conditions such as irritable bowel syndrome but it appears that it has been recommended for urinary symptoms. The claimant's pattern of use of this medication and the benefit to her from its use are unclear. There is no evidence of any gastrointestinal conditions for which it appears to be indicated and is benefitting

the claimant. The medical necessity of the use of hyoscyamine 0.375 mg has not been demonstrated.

L3-4 Transforaminal Epidural Steroid Injection with L2 Paravertebral Block: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections, Page(s): 79.

Decision rationale: The history and documentation do not objectively support the request for a repeat lumbar ESI at level L3-4 with an L1 paravertebral block. The MTUS state "ESI may be recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy).... Criteria for the use of Epidural steroid injections: 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants)....7) In the therapeutic phase, 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, with a general recommendation of no more than 4 blocks per region per year. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007)"There is no evidence of radiating pain that is consistent with radiculopathy at level L3-4 on PE and no EMG demonstrating radiculopathy has been reported. No focal neurologic deficits consistent with radiculopathy have been documented. There is no report of an MRI of the lumbar spine that demonstrates nerve root compression at the level to be injected. Her previous ESI only gave her 30-40% relief for an unknown duration. The medical necessity of this request for a repeat lumbar ESI at level L3-4 with an L2 paravertebral block has not been clearly demonstrated.