

Case Number:	CM14-0174177		
Date Assigned:	10/24/2014	Date of Injury:	08/14/1991
Decision Date:	12/03/2014	UR Denial Date:	10/06/2014
Priority:	Standard	Application Received:	10/20/2014

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 Orthopedic Surgery, has a subspecialty in Spine Fellowship 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:

According to the records made available for review, this is a 61-year-old female with an 8/14/91 date of injury. At the time (8/29/14) of request for authorization for TENS unit: some new pads, Epidural injection, Oxycodone 30mg Quantity: 120, Neurontin 800 mg Quantity: 120, Zanaflex 6mg Quantity: 60, and OxyContin 60mg Quantity: 60, there is documentation of subjective (severe back pain radiating to left buttock as well as posterior thigh and burning leg pain) and objective (lumbar muscle spasm upon palpation, positive bilateral straight leg raise, decreased sensory exam over left lateral calf and bottom of the foot, decreased deep tendon reflex at knee as well as right Achilles tendon reflex, and absent left Achilles tendon reflex) findings. Imaging findings reported MRI lumbar spine (12/16/13) revealed interval change with worsening broad-based disc protrusion at L4-5 entrapping the L5 nerve root; report not available for review). The current diagnoses are status post lumbar laminectomy, back pain, and lumbar discogenic pain. The treatment to date includes aqua therapy, TENS unit, physical therapy, activity modification, and ongoing treatment with OxyContin, Oxycodone, Neurontin, and Zanaflex. Medical report identifies that patient has 50% of pain reduction and 50% functional improvement with activities of daily living with pain medications; and TENS unit helps decrease pain. 8/24/14 medical report identifies a pain contract on file; and a plan for left L4-5 transforaminal epidural injection. Regarding TENS unit: some new pads, there is no documentation of outcomes in terms of function, and other ongoing pain treatment during the trial period (including medication use); and how often the TENS unit was used during the trial period. Regarding Epidural injection, there is no documentation of an imaging report. Regarding Oxycodone 30mg Quantity: 120, there is no documentation that a continuous, around-the-clock analgesic is needed for an extended period of time; and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a

result of specific use of Oxycodone. Regarding Neurontin 800 mg Quantity: 120, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of specific use of Neurontin. Regarding Zanaflex 6mg Quantity: 60, there is no documentation of acute exacerbations of chronic low back pain; an intention for short-term (less than two weeks) treatment; and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of specific use of Zanaflex. Regarding OxyContin 60mg Quantity: 60, there is no documentation that a continuous, around-the-clock analgesic is needed for an extended period of time; and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of specific use of OxyContin.

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS unit: some new pads: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrical nerve stimulation (TENS) Page(s): 113-117.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of pain of at least three months duration, evidence that other appropriate pain modalities have been tried (including medication) and failed, a statement identifying that the TENS unit will be used as an adjunct to a program of evidence-based functional restoration, and a treatment plan including the specific short- and long-term goals of treatment with the TENS, as criteria necessary to support the medical necessity of a month trial of a TENS unit. In addition, MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of how often the unit was used, outcomes in terms of pain relief and function, and other ongoing pain treatment during the trial period (including medication use), as criteria necessary to support the medical necessity of continued TENS unit. Within the medical information available for review, there is documentation of diagnoses of status post lumbar laminectomy, back pain, and lumbar discogenic pain. In addition there is documentation of ongoing treatment with TENS unit. However, despite documentation that TENS unit helps relieve pain, there is no (clear) documentation of outcomes in terms of function, and other ongoing pain treatment during the trial period (including medication use). In addition, there is no documentation of how often the TENS unit was used during the trial period. Therefore, based on guidelines and a review of the evidence, the request for TENS unit: some new pads are not medically necessary.

Epidural injection: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs).

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) Low Back, Epidural Steroid Injections (ESIs)

Decision rationale: MTUS reference to ACOEM guidelines identifies documentations of objective radiculopathy in an effort to avoid surgery as criteria necessary to support the medical necessity of epidural steroid injections. Official Disability Guidelines identifies documentation of subjective (pain, numbness, or tingling in a correlating nerve root distribution) and objective (sensory changes, motor changes, or reflex changes (if reflex relevant to the associated level) in a correlating nerve root distribution) radicular findings in each of the requested nerve root distributions, imaging (MRI, CT, myelography, or CT myelography & x-ray) findings (nerve root compression OR moderate or greater central canal stenosis, lateral recess stenosis, or neural foraminal stenosis) at each of the requested levels, failure of conservative treatment (activity modification, medications, and physical modalities), and no more than two nerve root levels injected one session; as criteria necessary to support the medical necessity of lumbar epidural steroid injection. Within the medical information available for review, there is documentation of diagnoses of status post lumbar laminectomy, back pain, and lumbar discogenic pain. In addition, given documentation of a plan for left L4-5 transforaminal epidural injection, there is documentation of no more than two nerve root levels injected one session. Furthermore, given documentation of subjective (back pain radiating to left buttock as well as posterior thigh) and objective (decreased sensory exam over left lateral calf and bottom of the foot, decreased deep tendon reflex at knee as well as right Achilles tendon reflex, and absent left Achilles tendon reflex) findings, there is documentation of subjective (pain) and objective (sensory changes and reflex changes) radicular findings in each of the requested nerve root distributions. Lastly, there is documentation of failure of conservative treatment (activity modification, medications, and physical modalities). However, despite documentation of medical reports' reported imaging findings (MRI of lumbar spine revealing interval change with worsening broad-based disc protrusion at L4-5 entrapping the L5 nerve root, there is no documentation of an imaging report. Therefore, based on guidelines and a review of the evidence, the request for epidural injection is not medically necessary.

Oxycodone 30mg Quantity: 120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids; Oxycodone Page(s): 74-80; 92. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of moderate to severe pain when a continuous, around-the-clock analgesic is needed for an extended period of time, as criteria necessary to support the medical necessity of Oxycodone. In addition, MTUS Chronic Pain Medical Treatment Guidelines identifies documentation that the prescriptions are from a single practitioner and are taken as directed; the

lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects, as criteria necessary to support the medical necessity of Oxycodone. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of status post lumbar laminectomy, back pain, and lumbar discogenic pain. In addition, there is documentation of severe pain; and ongoing treatment with Oxycodone. Furthermore, given documentation of a pain contract on file, there is documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. However, there is no documentation that a continuous, around-the-clock analgesic is needed for an extended period of time. In addition, despite documentation that patient has 50% of pain reduction and 50% functional improvement with activities of daily living with pain medications, there is no (clear) documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of specific use of Oxycodone. Therefore, based on guidelines and a review of the evidence, the request for Oxycodone 30mg Quantity: 120 is not medically necessary.

Neurontin 800 mg Quantity: 120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin) Page(s): 18-19. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of neuropathic pain, as criteria necessary to support the medical necessity of Neurontin (Gabapentin). MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnosis of status post lumbar laminectomy, back pain, and lumbar discogenic pain. In addition, there is documentation of neuropathic pain; and ongoing treatment with Neurontin. However, despite documentation that patient has 50% pain reduction and 50% functional improvement with activities of daily living with pain medications, there is no (clear) documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of specific use of Neurontin. Therefore, based on guidelines and a review of the evidence, the request for Neurontin 800 mg Quantity: 120 is not medically necessary.

Zanaflex 6mg Quantity: 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasticity/Antispasmodic Drugs; Tizanidine (Zanaflex) Page(s): 66. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Muscle relaxants (for pain); Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of spasticity, as criteria necessary to support the medical necessity of Tizanidine. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies that muscle relaxants are recommended as a second line option for short-term (less than two weeks) treatment of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. In addition, there is documentation of ongoing treatment with Zanaflex; and Zanaflex used as a second line option. However, despite documentation of muscle spasm, and given an 8/14/91 date of injury, there is no (clear) documentation of acute muscle spasm, or acute exacerbations of chronic low back pain. In addition, given documentation of records reflecting prescriptions for Zanaflex since at least 3/12/14, there is no documentation of an intention for short-term (less than two weeks) treatment. Furthermore, despite documentation that patient has 50% pain reduction and 50% functional improvement with activities of daily living with pain medications, there is no (clear) documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of specific use of Zanaflex. Therefore, based on guidelines and a review of the evidence, the request for Zanaflex 6mg Quantity: 60 is not medically necessary.

Oxycontin 60mg Quantity: 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids; Oxycodone Page(s): 74-80; 92. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of moderate to severe pain when a continuous, around-the-clock analgesic is needed for an extended period of time, as criteria necessary to support the medical necessity of OxyContin. In addition, MTUS Chronic Pain Medical Treatment Guidelines identifies documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of

pain relief, functional status, appropriate medication use, and side effects, as criteria necessary to support the medical necessity of OxyContin. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of status post lumbar laminectomy, back pain, and lumbar discogenic pain. In addition, there is documentation of severe pain; and ongoing treatment with OxyContin. Furthermore, given documentation of a pain contract on file, there is documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. However, there is no documentation that a continuous, around-the-clock analgesic is needed for an extended period of time. In addition, despite documentation that patient has 50% pain reduction and 50% functional improvement with activities of daily living with pain medications, there is no (clear) documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of specific use of OxyContin. Therefore, based on guidelines and a review of the evidence, the request for OxyContin 60mg Quantity: 60 is not medically necessary.