

Case Number:	CM15-0168815		
Date Assigned:	09/14/2015	Date of Injury:	08/28/1998
Decision Date:	11/05/2015	UR Denial Date:	08/11/2015
Priority:	Standard	Application Received:	08/27/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 injured worker is a 57 year old male, who sustained an industrial injury on 8-28-1998. Diagnoses include post laminectomy syndrome lumbar, lumbosacral spondylosis and sacroiliitis. Treatment to date has included lumbar fusion (undated), right sacroiliac radiofrequency ablation (5-05-2014), left sacroiliac joint radiofrequency ablation (11-11-2013) and medications. Medications as of 7-08-2015 include Gabapentin, omeprazole and Norco. Per the Primary Treating Physician's Progress Report dated 7-08-2015, the injured worker reported no changes in his symptomology. He rated his lower back pain as 7-8 out of 10 on a subjective scale. Objective findings included severe tenderness over both sacroiliac joints. He has been prescribed Gabapentin, Fenoprofen, Norco and omeprazole since at least 10-02-2014. Per the medical records dated 2-04-2015 to 7-08-2015 the injured worker's pain level has remained 6-7 out of 10 with medications. Authorization was requested on 7-30-2015, for bilateral sacroiliac joint injection, left sacroiliac bipolar radiofrequency ablation, right sacroiliac bipolar radiofrequency rhizotomy, and prescriptions for Fenoprofen, Lidocaine, Ultram ER, Gabapentin, omeprazole, Norco, and Terocin patch. On 8-11-2015, Utilization Review non-certified the request for bipolar right sacroiliac radiofrequency rhizotomy, bilateral sacroiliac joint injection, left sacroiliac bipolar radiofrequency ablation, Lidocaine and Terocin patch and modified the request for Ultram ER, Gabapentin, Norco and Fenoprofen. A progress report dated September 1, 2015 indicates the patient has had previous bilateral sacroiliac radiofrequency rhizotomy at least twice each side. The note indicates that "he substantially improves after that." The note states that his left leg "completely gave out and became numb and he fell." The note goes on to state that he has

numbness in the left leg all the way down below his knee. Lumbar exam identifies straight leg raise is "strongly positive on the left." Additionally the patient has decreased sensation in the left L4 and L5 and S1 dermatomes.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bipolar radiofrequency rhizotomy for the right and left SI joints: 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).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip and Pelvis Chapter, Sacroiliac joint radiofrequency neurotomy.

Decision rationale: Regarding the request for Repeat bilateral SI joint radiofrequency ablation, California MTUS does not address the issue. ODG states that the procedure is not recommended. The use of all of these techniques has been questioned, in part, due to the fact that the innervation of the SI joint remains unclear, and there is also controversy over the correct technique for radiofrequency denervation. They also note that a recent review of this intervention in a journal sponsored by the American Society of Interventional Pain Physicians found that the evidence was limited for this procedure. In light of the above issues, the currently requested Repeat bilateral SI joint radiofrequency ablation is not medically necessary.

Bilateral SI joint steroid injection, x 1: 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).

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Initial Care. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip and Pelvis Chapter, Sacroiliac Injections (Diagnostic/Therapeutic).

Decision rationale: Regarding the request for sacroiliac joint injections, guidelines state that sacroiliac injections (diagnostic/therapeutic) are not recommended. Within the documentation available for review, there are no peer reviewed studies provided, of sufficient power to overturn guideline recommendation against the use of this procedure. As such, the currently requested sacroiliac joint injections are not medically necessary.

Gabapentin 600mg, #90: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs).

Decision rationale: Regarding request for gabapentin (Neurontin), Chronic Pain Medical Treatment Guidelines state that antiepilepsy drugs are recommended for neuropathic pain. They go on to state that a good outcome is defined as 50% reduction in pain and a moderate response is defined as 30% reduction in pain. Guidelines go on to state that after initiation of treatment, there should be documentation of pain relief and improvement in function as well as documentation of side effects incurred with use. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects. Within the documentation available for review, it appears the patient has an acute exacerbation of what appears to be neuropathic pain with physical findings of numbness in the left lower extremity. Therefore, the use of gabapentin is reasonable. Of course, ongoing use will require documentation of analgesic efficacy, objective improvement, and discussion regarding side effects. However, a one-month prescription, as requested here, seems reasonable. Therefore, the currently requested gabapentin (Neurontin) is medically necessary.

Omeprazole 20mg, #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

Decision rationale: Regarding the request for omeprazole (Prilosec), California MTUS states that proton pump inhibitors are appropriate for the treatment of dyspepsia secondary to NSAID therapy or for patients at risk for gastrointestinal events with NSAID use. Within the documentation available for review, there is no indication that the patient has complaints of dyspepsia secondary to NSAID use, a risk for gastrointestinal events with NSAID use, or another indication for this medication. In light of the above issues, the currently requested omeprazole (Prilosec) is not medically necessary.

Norco 10/325mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids (Classification), Opioids, California Controlled Substance Utilization Review and Evaluation System (CURES) [DWC], Opioids, criteria for use, Opioids for chronic pain, Opioids for neuropathic pain, Opioids for osteoarthritis, Opioids, cancer pain vs. nonmalignant pain, Opioids, dealing with misuse & addiction, Opioids, differentiation: dependence & addiction, Opioids, dosing, Opioids, indicators for addiction, Opioids, long-term assessment.

Decision rationale: Regarding the request for Norco (hydrocodone/acetaminophen), California Pain Medical Treatment Guidelines state that this is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, it appears the patient has an acute exacerbation of severe pain with physical findings of numbness in the left lower extremity. Therefore, the use of norco would be reasonable to address the current exacerbation. Unfortunately, the current request does not include a quantity or directions on how the medication is to be taken. Guidelines do not support open-ended application of any medication, and there is no provision to modify the current request. Therefore, the currently requested Norco (hydrocodone/acetaminophen) is not medically necessary.

Ultram ER 150mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids (Classification), Opioids, California Controlled Substance Utilization Review and Evaluation System (CURES) [DWC], Opioids, criteria for use, Opioids for chronic pain, Opioids for neuropathic pain, Opioids for osteoarthritis, Opioids, cancer pain vs. nonmalignant pain, Opioids, dealing with misuse & addiction, Opioids, differentiation: dependence & addiction, Opioids, dosing, Opioids, indicators for addiction, Opioids, long-term assessment.

Decision rationale: Regarding the request for Ultram (tramadol), California Pain Medical Treatment Guidelines state that this is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, it appears the patient has an acute exacerbation of severe pain with physical findings of numbness in the left lower extremity. Therefore, the use of Ultram would be reasonable to address the current exacerbation. Unfortunately, the current request does not include a quantity or directions on how the medication is to be taken. Guidelines do not support open-ended application of any medication, and there is no provision to modify the current request. Therefore, the currently requested Ultram (tramadol) is not medically necessary.

Fenoprofen 400mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs), NSAIDs, GI symptoms &

cardiovascular risk, NSAIDs, hypertension and renal function, NSAIDs, specific drug list & adverse effects.

Decision rationale: Regarding the request for Fenopufen, Chronic Pain Medical Treatment Guidelines state that NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Within the documentation available for review, it appears the patient has an acute exacerbation of severe pain with physical findings of numbness in the left lower extremity. Therefore, the use of Fenopufen would be reasonable to address the current exacerbation. Unfortunately, the current request does not include a quantity or directions on how the medication is to be taken. Guidelines do not support open-ended application of any medication, and there is no provision to modify the current request. Therefore, the currently requested Fenopufen is not medically necessary.

Lidocaine 4%: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: Regarding request for topical lidocaine, Chronic Pain Medical Treatment Guidelines recommend the use of topical lidocaine for localized peripheral pain after there has been evidence of a trial of the 1st line therapy such as tri-cyclic antidepressants, SNRIs, or antiepileptic drugs. Guidelines go on to state that no commercially approved topical formulations of lidocaine cream, lotion, or gel are indicated for neuropathic pain. Within the documentation available for review, there is no indication that the patient has failed first-line therapy recommendations. Furthermore, guidelines do not support the use of topical lidocaine preparations which are not in patch form. As such, the currently requested topical lidocaine is not medically necessary.

Terocin patch: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: Regarding the request for Terocin, Terocin is a combination of methyl salicylate, menthol, lidocaine and capsaicin. Chronic Pain Medical Treatment Guidelines state that any compounded product that contains at least one drug or drug class that is not recommended, is not recommended. Regarding the use of topical nonsteroidal anti-inflammatory, guidelines state that the efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the 1st 2 weeks of treatment

osteoarthritis, but either not afterwards, or with the diminishing effect over another two-week period. Regarding use of capsaicin, guidelines state that it is recommended only as an option for patients who did not respond to or are intolerant to other treatments. Regarding the use of topical lidocaine, guidelines state that it is recommended for localized peripheral pain after there is evidence of a trial of first-line therapy. Within the documentation available for review, there is no indication that the patient is unable to tolerate oral NSAIDs. Oral NSAIDs have significantly more guideline support compared with topical NSAIDs. Additionally, there is no indication that the topical NSAID is going to be used for short duration. Additionally, there is no documentation of localized peripheral pain with evidence of failure of first-line therapy as recommended by guidelines prior to the initiation of topical lidocaine. Finally, there is no indication that the patient has been intolerant to or did not respond to other treatments prior to the initiation of capsaicin therapy. In the absence of clarity regarding those issues, the currently requested Terocin is not medically necessary.