

Case Number:	CM15-0093061		
Date Assigned:	05/19/2015	Date of Injury:	06/12/2009
Decision Date:	06/26/2015	UR Denial Date:	04/27/2015
Priority:	Standard	Application Received:	05/14/2015

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: Family Practice

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 65-year-old female, with a reported date of injury of 06/12/2009. The diagnoses include lumbar postlaminectomy syndrome, lumbar scoliosis, and chronic pain. Treatments to date have included an MRI of the lumbar spine on 09/13/2014 which showed decompressive laminectomy at L3-4 and L4-5 and mild anterolisthesis of L4 over L5; a two-level lumbar fusion from L3-L5 in 2012; oral pain medications; and electrodiagnostic study in 06/2013. The medical report dated 10/30/2014 indicates that the injured worker reported increasing pain in her legs. Her legs had been giving out. The injured worker also had significant back pain. She stated that her upper extremity symptoms had improved somewhat, but she would still get numbness in her hands bilaterally and left upper extremity. The physical examination showed a bit of agitation at the end of the visit. No other findings were documented. The treating physician requested a pain pump, Norco 10/325mg #90, Valium 5mg #30, and a wheeled walker with a seat.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pain pump: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Implantable infusion pumps Page(s): 53.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Implantable Drug-Delivery Systems Page(s): 52-54.

Decision rationale: The MTUS/Chronic Pain Medical Treatment Guidelines comment on the use of a pain pump, also known as an implantable drug-delivery system (IDDS), as a treatment modality. A pain pump is recommended only as an end-stage treatment alternative for selected patients for specific conditions indicated below, after failure of at least 6 months of less invasive methods, and following a successful temporary trial. Results of studies of opioids for musculoskeletal conditions (as opposed to cancer pain) generally recommend short use of opioids for severe cases, not to exceed 2 weeks, and do not support chronic use (for which a pump would be used), although IDDSs may be appropriate in selected cases of chronic, severe low back pain or failed back syndrome. This treatment should only be used relatively late in the treatment continuum, when there is little hope for effective management of chronic intractable pain from other therapies. Permanently implanted intrathecal (intraspinal) infusion pumps for the administration of opiates or non-opiate analgesics, in the treatment of chronic intractable pain, are considered medically necessary when: Used for the treatment of malignant (cancerous) pain and all of the following criteria are met: 1. Strong opioids or other analgesics in adequate doses, with fixed schedule (not PRN) dosing, have failed to relieve pain or intolerable side effects to systemic opioids or other analgesics have developed; and 2. Life expectancy is greater than 3 months (less invasive techniques such as external infusion pumps provide comparable pain relief in the short term and are consistent with standard of care); and 3. Tumor encroachment on the thecal sac has been ruled out by appropriate testing; and 4. No contraindications to implantation exist such as sepsis or coagulopathy; and 5. A temporary trial of spinal (epidural or intrathecal) opiates has been successful prior to permanent implantation as defined by a 50% reduction in pain. A temporary trial of intrathecal (intraspinal) infusion pumps is considered medically necessary only when criteria 1-4 above are met. Used for the treatment of non-malignant (non- cancerous) pain with a duration of greater than 6 months and all of the following criteria are met: 1. Documentation, in the medical record, of the failure of 6 months of other conservative treatment modalities (pharmacologic, surgical, psychologic or physical), if appropriate and not contraindicated; and 2. Intractable pain secondary to a disease state with objective documentation of pathology in the medical record; and 3. Further surgical intervention or other treatment is not indicated or likely to be effective; and 4. Psychological evaluation has been obtained and evaluation states that the pain is not primarily psychologic in origin and that benefit would occur with implantation despite any psychiatric comorbidity; and 5. No contraindications to implantation exist such as sepsis or coagulopathy; and 6. A temporary trial of spinal (epidural or intrathecal) opiates has been successful prior to permanent implantation as defined by at least a 50% to 70% reduction in pain and documentation in the medical record of functional improvement and associated reduction in oral pain medication use. A temporary trial of intrathecal (intraspinal) infusion pumps is considered medically necessary only when criteria 1-5 above are met. In this case, there is insufficient documentation to indicate that the patient meets these above cited MTUS guidelines for the use of a pain pump. Further, there is no documentation to indicate that a pump is being considered for a temporary trial during which

objective measures of functional outcomes will be assessed to determine its effectiveness. For these reasons, a pain pump is not medically necessary.

Norco (Hydroco/APA) 10/325mg #270: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for chronic pain Page(s): 80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-78, 80.

Decision rationale: The MTUS/Chronic Pain Medical Treatment Guidelines comment on the long-term use of opioids, including Norco. These guidelines have established criteria on the use of opioids for the ongoing management of pain. Actions should include: prescriptions from a single practitioner and from a single pharmacy. The lowest possible dose should be prescribed to improve pain and function. There should be an ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. Pain assessment should include: current pain, the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. There should be evidence of documentation of the "4 A's for Ongoing Monitoring." These four domains include: pain relief, side effects, physical and psychological functioning, and the occurrence of any potentially aberrant drug-related behaviors. Further, there should be consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain that does not improve on opioids in 3 months. There should be consideration of an addiction medicine consult if there is evidence of substance misuse (Pages 76-78). Finally, the guidelines indicate that for chronic pain, the long-term efficacy of opioids is unclear. Failure to respond to a time-limited course of opioids has led to the suggestion of reassessment and consideration of alternative therapy (Page 80). Based on the review of the medical records, there is insufficient documentation in support of these stated MTUS/Chronic Pain Medical Treatment Guidelines for the ongoing use of opioids. There is insufficient documentation of the "4 A's for Ongoing Monitoring." The treatment course of opioids in this patient has extended well beyond the timeframe required for a reassessment of therapy. In summary, there is insufficient documentation to support the chronic use of an opioid in this patient. Treatment with Norco is not medically necessary.

Valium (Diazepam) 5mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 24.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: The MTUS/Chronic Pain Medical Treatment Guidelines comment on the use of benzodiazepines, including Valium, as a treatment modality. Benzodiazepines 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 records indicate that Valium is being used as a long-term treatment strategy for this patient's symptoms. As noted in the above-cited guidelines, long-term use of a benzodiazepine is not recommended. For this reason, Valium is not medically necessary.

Wheeled walker with seat: 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), Knee and Leg.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medicare Guidelines/Use of a Walker www.mobilitycare.com/medicare_guidelines#answer2.

Decision rationale: The MTUS and Official Disability Guidelines do not comment on the use of a wheeled walker for patients with low back conditions. The Medicare guidelines state the following: Medicare pays for walkers with or without wheels if a patient has: A mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADL) in the home; The patient is able to safely use the walker and the functional mobility deficit can be sufficiently resolved with use of a walker. In this case, the medical records indicate that the provider has been unable to determine etiology of this patient's leg weakness; as noted the MRI and electrophysiologic studies did not demonstrate an organic cause for the lower leg weakness. Further, there is no assessment in the record that the patient is impaired in the ability to participate in one or more mobility-related activities of daily living and that the patient is able to safely use the walker and that the functional mobility deficit can be sufficiently resolved with the use of a walker. For these reasons, a wheeled walker with a seat is not medically necessary without this documentation.