

<b>Case Number:</b>	CM13-0049727		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	10/08/2008
<b>Decision Date:</b>	08/12/2014	<b>UR Denial Date:</b>	10/24/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/08/2013

### 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 Physical Medicine and Rehabilitation and is licensed to practice in Illinois. 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 injured worker is a 59-year-old female who reported a re-injury to her lower back while caring for a heavy patient on 10/08/2008. In the clinical notes dated 09/26/2013 the injured worker complained of lower back pain with the left side worse than the right and lower extremity pain, which was noted to be stable and improved. It was noted that the injured worker stated she had constant pain in her lower back that radiated down through both legs into the feet. Her pain level status was annotated as 9/10 with the least pain score of 6/10 and the usual pain score of 8/10. It was noted that the injured worker's medication usage was increased. Prior treatment included transforaminal epidural steroid injections at L5-S1 dated 05/30/2013, 06/06/2012, 11/02/2011, 05/12/2011, 11/23/2010, and 01/22/2010; physical therapy and pain medications. Surgical history included arthroscopic surgery and ACL replacement 1981, carpal tunnel left 2000, and arthroscopic shoulder surgery left 2000. The injured worker's medication regimen included Lipitor 40 mg, aspirin 81 mg, Zoloft 100 mg, Butrans 20 mcg per hour patch weekly 1 patch apply 1 patch every 7 days, Dexilant 60 mg delayed release 1 capsule once a day, and ibuprofen 800 mg every 8 hours. Past medical history included chronic bronchitis, asthma, peptic ulcer disease, cholesterol, OCD, hypercholesterolemia, and GERD. The physical examination of the spine revealed facet tenderness on the right lumbar facets, tender on the left lumbar facets, but left side worse than right. The facet loading test was positive bilaterally with left side worse than the right. Sacroiliac joints non-tender bilaterally. The spine range of motion was noted as restricted and painful bilaterally. The neurological physical examination revealed decreased sensation to touch in pinwheel in the tops of bilateral feet and central 3 toes, possible L5 decreased sensation in the 2nd, 3rd, and 4th toe of each foot with micro fiber and vibratory sensation intact. It was also noted there was diminished sensation in the L5 dermatome of both legs. The physical examination of the motor strength revealed some gross non-focal weakness

observed with plantar flexion. It was also noted that the injured worker was suffering from chronic low back pain, as well as radicular symptoms. It was also noted that the injured worker's radicular symptoms had been adequately addressed by epidural steroid injections. It was also noted that the injured worker had failed conservative management to include physical therapy sessions, NSAIDs, and independent exercise program. The diagnoses included chronic pain syndrome; disc displacement with radiculitis - lumbar; lumbosacral spondylosis with myelopathy; morbid obesity; chronic peptic ulcer unspecified site without mention of hemorrhage, perforation, or obstruction, and dietary surveillance and counseling. The treatment plan included a refill of the Butrans Patch weekly 20 mcg per hour 1 patch transdermal apply 1 patch every 7 days 30 days quantity 4, no refills; Dexilant capsule delayed release 60 mg 1 capsule orally once a day 30 days quantity 30; ibuprofen tablet 800 mg 1 tab orally every 8 hours with food 30 days #90 with refills of 3, and due to failure of conservative management a request for diagnostic medial branch blocks left L3, L4, L5 under fluoroscopic guidance aimed at L4-5 left and left L5-S1 facet joints. The request for diagnostic medial branch blocks left L3, L4, L5 under fluoroscopic guidance for the diagnoses of chronic pain syndrome was submitted on 10/15/2013 and the Request for Authorization for Butrans Patch 20 mcg, Dexilant 60 mg, and ibuprofen 800 mg for chronic pain syndrome was submitted on 10/15/2013.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **BUTRANS PATCH #4: 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 Buprenorphine Page(s): 26-27.

**Decision rationale:** The California MTUS Guidelines state that Buprenorphine is recommended as an option for chronic pain, especially after detoxification in injured workers who have a history of opioid addiction. In the clinical notes provided for review, there is a lack of documentation of the injured worker's pain level status with the use of the Butrans Patch. It is annotated that the injured worker did not have pain medications for 2 months. However, it is also annotated that she had increased the use of medication. Furthermore, the request lacks the frequency of the use of the Butrans Patch. Therefore, the request for Butrans Patch #4 is not medically necessary.

#### **DEXILANT #30: 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 NSAIDs, GI symptoms and cardiovascular risk Page(s): 68.

**Decision rationale:** The California MTUS Guidelines state that to determine if the injured worker is at risk for gastrointestinal events the following criteria should be evaluated, age greater than 65 years; history of peptic ulcer, GI bleeding or perforation; concurrent use of aspirin (ASA), corticosteroids, and/or anticoagulants; or high dose/multiple NSAID (e.g. NSAID plus low dose ASA). In the clinical notes provided for review, it is annotated that the injured worker has a diagnosis of chronic peptic ulcer; however, it is also annotated that the injured worker is on NSAIDs of which is noted to not have efficacy for the injured worker. Furthermore, there is lack of documentation of the injured worker's side effects pertaining to the pain medications or medications that the injured worker has been taking. Therefore, the request for Dexilant #30 is not medically necessary.

**IBUPROFEN #90:** 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 NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-68, 72.

**Decision rationale:** The California MTUS Guidelines state that NSAIDs are recommended as an option for short term symptomatic relief. The guidelines also state that low back pain with NSAIDs were no more effective than other drugs such as acetaminophen, narcotic analgesics and muscle relaxants. It is also noted that NSAIDs have more adverse effects than placebo and acetaminophen, but fewer effects than muscle relaxants and narcotic analgesics. In the clinical notes provided for review, it is annotated that the injured worker did not have relief with the use of NSAIDs. There is also a lack of documentation of the measurable pain level status with the use of pain medications. Furthermore, it is indicated that the injured worker has a history of GERD and peptic ulcer disease, of which the use of ibuprofen is known to cause side effects. Therefore, the request for ibuprofen #90 is not medically necessary.

**DIAGNOSTIC MEDICAL BRANCH BLOCKS LEFT L3, L4, AND L5 UNDER FLUOROSCOPIC GUIDANCE:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Facet joint diagnostic blocks (injections).

**Decision rationale:** The California MTUS ACOEM states that invasive techniques (e.g. local injections and facet joint injections of cortisone or Lidocaine) are of questionable merit. The Official Disability Guidelines (ODG) state that facet joint diagnostic blocks (injections) are recommended no more than 1 set of medial branch diagnostic blocks prior to facet neurotomy, if neurotomy is chosen as an option for treatment (a procedure that is still considered under study). The criteria for the use of diagnostic blocks for facet (mediated pain) include: 1 set of diagnostic

medial branch blocks is required with response of greater than 70%; limited to injured workers with low back pain that is non-radicular and at no more than 2 levels bilaterally; there is documentation of failure of conservative treatment (including home exercise, physical therapy, and NSAIDs) prior to the procedure for at least 4 to 6 weeks; no more than 2 facet joints levels are injected in 1 session; they recommend volume of no more than 0.5 mL of injectate is given to each joint. No pain medication from home should be taken for at least 4 hours prior to the diagnostic block and for 4 to 6 hours afterwards. Opioids should not be given as a sedative during the procedure. Diagnostic facet blocks should be performed in injured workers in whom a surgical procedure is anticipated. Diagnostic facet blocks should not be performed in injured workers who have had a previous fusion procedure at the planned injection level. In the clinical notes provided for review, it is annotated that the injured worker has had ESIs with some efficacy. However, the injured worker still complains of radicular symptoms into the lower extremities. There is also a lack of documentation of neurological and functional tests to indicate the presence of non-radicular pain such as a negative straight leg raise. Furthermore, there is lack of documentation of any indication of the injured worker to be a surgical candidate. Therefore, the request for diagnostic medial branch blocks left L3, L4, and L5 under fluoroscopic guidance is not medically necessary.