

Case Number:	CM14-0014675		
Date Assigned:	02/28/2014	Date of Injury:	02/05/2007
Decision Date:	07/24/2014	UR Denial Date:	01/22/2014
Priority:	Standard	Application Received:	02/05/2014

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 & Preventive 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 patient is a 49 year old male with a date of injury of 1/1/1995 to 11/16/2012. The patient stated he was lifting a table saw and began feeling a sharp pain on his right side lower back. Currently, the patient is on modified duty. Per 12/26/2013 progress report (██████████), the patient complained of pain in his neck traveling to his left shoulder which was aching and rated 4/10; numbness and tingling in his neck and left shoulder; weakness in his left hand and dropping things; global headache for a week 4-5/10 pain; and difficulty falling asleep due to pain. The patient underwent diagnostic cervical epidural steroid injection on 10/31/2013. Pain was reduced after the procedure and went up to 4/10 after one month. MRI of the cervical spine (10/9/2013) noted straightening of the cervical spine; disc desiccation noted at C2/C3 and C3/C4; early disc desiccation noted at C4/C5, C6/C7, and C7/T1; reduced intervertebral disc height noted at C5/C6 and C6/C7; diffuse disc protrusion at C3/C4, C4/C5, and C6/C7; focal central disc protrusion at C5/C6. Examination (12/26/2013) noted normal grip strength; tenderness at AC joint, supraspinatous, infraspinatous, and bicipital on the left; Yergason's sign negative; Empty can test and Codman drop arm negative on right shoulder and positive on left shoulder; decreased left shoulder flexion, extension, and abduction range of motion; paraspinal tenderness bilaterally at C4/C5 to C6/C7; Spurling and Foraminal compression test positive bilaterally; distraction test negative; reduced cervical flexion and extension range of motion; and noted sensory deficit at L4 and L5 dermatome on the left. Diagnoses were cervicalgia; displacement of cervical intervertebral disc without myelopathy; cervical facet joint syndrome/hypertrophy; displacement of lumbar intervertebral disc without myelopathy; lower back pain with bilateral lower extremity radiculopathy; degeneration of lumbar or lumbosacral intervertebral disc; spinal stenosis of unspecified reason; myalgia; insomnia; lumbar spondylosis; bilateral neuroforaminal stenosis at L5/S1; annular tear at L4/L5; osteoarthritis localized left

shoulder region AC joint; and left subacromial/subdeltoid bursitis. The provider recommended second diagnostic cervical epidural steroid injection at C5/C6 and C6/C7; cervical facet joint block at the medial branch at C3/C4, C4/C5, C5/C6, and C6/C7; injection to the left AC joint and left subacromial/subdeltoid bursa; clearance from an internal medicine specialist; psychological evaluation; and a course of medications and transdermal analgesics.

IMR ISSUES, DECISIONS AND RATIONALES

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

SECOND DIAGNOSTIC CERVICAL EPIDURAL STEROID INJECTION AT DISC LEVELS C5-C6 .: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper back (Acute & Chronic) Epidural steroid injection (ESI).

Decision rationale: The Official Disability Guidelines state epidural steroid injections are, "Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). Criteria for use of Epidural steroid injections, diagnostic: To determine the level of radicular pain, in cases where diagnostic imaging is ambiguous, including the example below: (1) To help to evaluate a pain generator when physical signs and symptoms differ from that found on imaging studies; (2) To help to evaluate a pain generator when there is evidence of multi-level nerve root compression; (3) To help to evaluate a pain generator when clinical findings are suggestive of radiculopathy (e.g. dermatomal distribution), and imaging studies have suggestive cause for symptoms but are inconclusive; (4) To help to identify the origin of pain in patients who have had previous spinal surgery." A review of submitted documents did not demonstrate the patient had met the criteria for diagnostic cervical epidural steroid injection at disc level C5/C6. The request is not medically necessary.

SECOND DIAGNOSTIC CERVICAL EPIDURAL STEROID INJECTION AT DISC LEVELS C6-C7: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper back (Acute & Chronic) Epidural steroid injection (ESI).

Decision rationale: The Official Disability Guidelines state epidural steroid injections are, "Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). Criteria for use of Epidural steroid

injections, diagnostic: To determine the level of radicular pain, in cases where diagnostic imaging is ambiguous, including the example below: (1) To help to evaluate a pain generator when physical signs and symptoms differ from that found on imaging studies; (2) To help to evaluate a pain generator when there is evidence of multi-level nerve root compression; (3) To help to evaluate a pain generator when clinical findings are suggestive of radiculopathy (e.g. dermatomal distribution), and imaging studies have suggestive cause for symptoms but are inconclusive; (4) To help to identify the origin of pain in patients who have had previous spinal surgery." A review of submitted documents did not demonstrate the patient had met the criteria for diagnostic cervical epidural steroid injection at disc level C6/C7. The request is not medically necessary.

CERVICAL FACET JOINT BLOCK AT LEVELS C3-C4: 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) Neck and Upper back (Acute & Chronic), Facet joint diagnostic blocks.

Decision rationale: The Official Disability Guidelines state facet joint diagnostic blocks are, "Recommended prior to facet neurotomy (a procedure that is considered "under study"). Diagnostic blocks are performed with the anticipation that if successful, treatment may proceed to facet neurotomy at the diagnosed levels... Criteria for the use of diagnostic blocks for facet nerve pain: Clinical presentation should be consistent with facet joint pain, signs & symptoms. 1. One set of diagnostic medial branch blocks is required with a response of 70%. The pain response should be approximately 2 hours for Lidocaine.2. Limited to patients with cervical pain that is non-radicular and at no more than two levels bilaterally.3. There is documentation of failure of conservative treatment (including home exercise, PT and NSAIDs) prior to the procedure for at least 4-6 weeks.4. No more than 2 joint levels are injected in one session (see above for medial branch block levels).5. Recommended volume of no more than 0.5 cc of injectate is given to each joint, with recent literature suggesting a volume of 0.25 cc to improve diagnostic accuracy.6. No pain medication from home should be taken for at least 4 hours prior to the diagnostic block and for 4 to 6 hours afterward.7. Opioids should not be given as a "sedative" during the procedure.8. The use of IV sedation may be grounds to negate the results of a diagnostic block, and should only be given in cases of extreme anxiety.9. The patient should document pain relief with an instrument such as a VAS scale, emphasizing the importance of recording the maximum pain relief and maximum duration of pain. The patient should also keep medication use and activity logs to support subjective reports of better pain control. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. It is currently not recommended to perform facet blocks on the same day of treatment as epidural steroid injections or stellate ganglion blocks or sympathetic blocks or trigger point injections as this may lead to improper diagnosis or unnecessary treatment." A review of submitted documents did not demonstrate the patient had

met the criteria for cervical facet joint block at level C3/C4. The request is not medically necessary.

CERVICAL FACET JOINT BLOCK AT LEVELS C4-C5: 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) Neck and Upper back (Acute & Chronic), Facet joint diagnostic blocks.

Decision rationale: The Official Disability Guidelines state facet joint diagnostic blocks are, "Recommended prior to facet neurotomy (a procedure that is considered "under study"). Diagnostic blocks are performed with the anticipation that if successful, treatment may proceed to facet neurotomy at the diagnosed levels... Criteria for the use of diagnostic blocks for facet nerve pain: Clinical presentation should be consistent with facet joint pain, signs & symptoms. 1. One set of diagnostic medial branch blocks is required with a response of 70%. The pain response should be approximately 2 hours for Lidocaine.2. Limited to patients with cervical pain that is non-radicular and at no more than two levels bilaterally.3. There is documentation of failure of conservative treatment (including home exercise, PT and NSAIDs) prior to the procedure for at least 4-6 weeks.4. No more than 2 joint levels are injected in one session (see above for medial branch block levels).5. Recommended volume of no more than 0.5 cc of injectate is given to each joint, with recent literature suggesting a volume of 0.25 cc to improve diagnostic accuracy.6. No pain medication from home should be taken for at least 4 hours prior to the diagnostic block and for 4 to 6 hours afterward.7. Opioids should not be given as a "sedative" during the procedure.8. The use of IV sedation may be grounds to negate the results of a diagnostic block, and should only be given in cases of extreme anxiety.9. The patient should document pain relief with an instrument such as a VAS scale, emphasizing the importance of recording the maximum pain relief and maximum duration of pain. The patient should also keep medication use and activity logs to support subjective reports of better pain control.10. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated.11. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level.12. It is currently not recommended to perform facet blocks on the same day of treatment as epidural steroid injections or stellate ganglion blocks or sympathetic blocks or trigger point injections as this may lead to improper diagnosis or unnecessary treatment." A review of submitted documents did not demonstrate the patient had met the criteria for cervical facet joint block at level C4/C5. The request is not medically necessary.

CERVICAL FACET JOINT BLOCK AT LEVELS C5-C6: 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) Neck and Upper back (Acute & Chronic), Facet joint diagnostic blocks.

Decision rationale: The Official Disability Guidelines state facet joint diagnostic blocks are, "Recommended prior to facet neurotomy (a procedure that is considered "under study"). Diagnostic blocks are performed with the anticipation that if successful, treatment may proceed to facet neurotomy at the diagnosed levels... Criteria for the use of diagnostic blocks for facet nerve pain: Clinical presentation should be consistent with facet joint pain, signs & symptoms. 1. One set of diagnostic medial branch blocks is required with a response of 70%. The pain response should be approximately 2 hours for Lidocaine.2. Limited to patients with cervical pain that is non-radicular and at no more than two levels bilaterally.3. There is documentation of failure of conservative treatment (including home exercise, PT and NSAIDs) prior to the procedure for at least 4-6 weeks.4. No more than 2 joint levels are injected in one session (see above for medial branch block levels).5. Recommended volume of no more than 0.5 cc of injectate is given to each joint, with recent literature suggesting a volume of 0.25 cc to improve diagnostic accuracy.6. No pain medication from home should be taken for at least 4 hours prior to the diagnostic block and for 4 to 6 hours afterward.7. Opioids should not be given as a "sedative" during the procedure.8. The use of IV sedation may be grounds to negate the results of a diagnostic block, and should only be given in cases of extreme anxiety.9. The patient should document pain relief with an instrument such as a VAS scale, emphasizing the importance of recording the maximum pain relief and maximum duration of pain. The patient should also keep medication use and activity logs to support subjective reports of better pain control.10. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated.11. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level.12. It is currently not recommended to perform facet blocks on the same day of treatment as epidural steroid injections or stellate ganglion blocks or sympathetic blocks or trigger point injections as this may lead to improper diagnosis or unnecessary treatment." A review of submitted documents did not demonstrate the patient had met the criteria for cervical facet joint block at level C5/C6. The request is not medically necessary.

CERVICAL FACET JOINT BLOCK AT LEVELS C6-C7: 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) Neck and Upper back (Acute & Chronic), Facet joint diagnostic blocks.

Decision rationale: The Official Disability Guidelines state facet joint diagnostic blocks are, "Recommended prior to facet neurotomy (a procedure that is considered "under study"). Diagnostic blocks are performed with the anticipation that if successful, treatment may proceed to facet neurotomy at the diagnosed levels... Criteria for the use of diagnostic blocks for facet nerve pain: Clinical presentation should be consistent with facet joint pain, signs & symptoms. 1.

One set of diagnostic medial branch blocks is required with a response of 70%. The pain response should be approximately 2 hours for Lidocaine.2. Limited to patients with cervical pain that is non-radicular and at no more than two levels bilaterally.3. There is documentation of failure of conservative treatment (including home exercise, PT and NSAIDs) prior to the procedure for at least 4-6 weeks.4. No more than 2 joint levels are injected in one session (see above for medial branch block levels).5. Recommended volume of no more than 0.5 cc of injectate is given to each joint, with recent literature suggesting a volume of 0.25 cc to improve diagnostic accuracy.6. No pain medication from home should be taken for at least 4 hours prior to the diagnostic block and for 4 to 6 hours afterward.7. Opioids should not be given as a "sedative" during the procedure.8. The use of IV sedation may be grounds to negate the results of a diagnostic block, and should only be given in cases of extreme anxiety.9. The patient should document pain relief with an instrument such as a VAS scale, emphasizing the importance of recording the maximum pain relief and maximum duration of pain. The patient should also keep medication use and activity logs to support subjective reports of better pain control.10. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated.11. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level.12. It is currently not recommended to perform facet blocks on the same day of treatment as epidural steroid injections or stellate ganglion blocks or sympathetic blocks or trigger point injections as this may lead to improper diagnosis or unnecessary treatment." A review of submitted documents did not demonstrate the patient had met the criteria for cervical facet joint block at level C6/C7. The request is not medically necessary.

INJECTION TO LEFT AC JOINT: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 213.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (Acute & Chronic), Steroid injections.

Decision rationale: Regarding injection to the left AC joint, the ACOEM guidelines state, "Invasive techniques have limited proven value. If pain with elevation significantly limits activities, a subacromial injection of local anesthetic and a corticosteroid preparation may be indicated after conservative therapy (i.e., strengthening exercises and nonsteroidal anti-inflammatory drugs) for two to three weeks. The evidence supporting such an approach is not overwhelming. The total number of injections should be limited to three per episode, allowing for assessment of benefit between injections." Further, the Official Disability Guidelines listed, "Criteria for Steroid injections: Diagnosis of adhesive capsulitis, impingement syndrome, or rotator cuff problems, except for post-traumatic impingement of the shoulder; Not controlled adequately by recommended conservative treatments (physical therapy and exercise, NSAIDs or acetaminophen), after at least 3 months; Pain interferes with functional activities (e.g., pain with elevation is significantly limiting work); Intended for short-term control of symptoms to resume conservative medical management; Generally performed without fluoroscopic or ultrasound guidance;- Only one injection should be scheduled to start, rather than a series of three; A second injection is not recommended if the first has resulted in complete resolution of symptoms,

or if there has been no response; With several weeks of temporary, partial resolution of symptoms, and then worsening pain and function, a repeat steroid injection may be an option;- The number of injections should be limited to three." The submitted records did not demonstrate the patient meeting the criteria for an injection to the left AC joint. Therefore, the request is no medically necessary.

INJECTION TO THE LEFT SUBACROMIAL/SUBDELTOID BURSA: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 213.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (Acute & Chronic), Steroid injections.

Decision rationale: Regarding injection to left subacromial/subdeltoid bursa, the ACOEM guidelines state, "Invasive techniques have limited proven value. If pain with elevation significantly limits activities, a subacromial injection of local anesthetic and a corticosteroid preparation may be indicated after conservative therapy (i.e., strengthening exercises and nonsteroidal anti-inflammatory drugs) for two to three weeks. The evidence supporting such an approach is not overwhelming. The total number of injections should be limited to three per episode, allowing for assessment of benefit between injections." Further, the Official Disability Guidelines listed, " Criteria for Steroid injections:- Diagnosis of adhesive capsulitis, impingement syndrome, or rotator cuff problems, except for post-traumatic impingement of the shoulder; Not controlled adequately by recommended conservative treatments (physical therapy and exercise, NSAIDs or acetaminophen), after at least 3 months; Pain interferes with functional activities (e.g., pain with elevation is significantly limiting work); Intended for short-term control of symptoms to resume conservative medical management; Generally performed without fluoroscopic or ultrasound guidance; Only one injection should be scheduled to start, rather than a series of three; A second injection is not recommended if the first has resulted in complete resolution of symptoms, or if there has been no response; With several weeks of temporary, partial resolution of symptoms, and then worsening pain and function, a repeat steroid injection may be an option; The number of injections should be limited to three." The submitted records did not demonstrate the patient meeting the criteria for an injection to the left subacromial/subdeltoid bursa. Therefore, the request is no medically necessary.

CLEARANCE FROM AN INTERNAL MEDICINE SPECIALIST: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), Chapter 7, pg. 127.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 166, 171, 180.

Decision rationale: The ACOEM guidelines state for referrals, "Certain findings in this assessment raise suspicion of serious underlying medical conditions; these are referred to as red flags (see Table 8-1). Their absence rules out the need for special studies, referral, or inpatient care during the first four weeks, during which time spontaneous recovery is expected (provided any inciting workplace factors are mitigated). Assessing Red Flags and Indications for Immediate Referral: Physical examination evidence of severe neurologic compromise that correlates with the medical history and test results may indicate a need for immediate consultation. The examination may further reinforce or reduce suspicions of tumor, infection, fracture, or dislocation. Referral for surgical consultation is indicated for patients who have:- Persistent, severe, and disabling shoulder or arm symptoms- Activity limitation for more than one month or with extreme progression of symptoms- Clear clinical, imaging, and electrophysiologic evidence, consistently indicating the same lesion that has been shown to benefit from surgical repair in both the short- and long-term- Unresolved radicular symptoms after receiving conservative treatment. Patients with acute neck or upper back pain alone, without findings of serious conditions or significant nerve root compromise, rarely benefit from either surgical consultation or surgery. If there is no clear indication for surgery, referring the patient to a physical medicine and rehab (PM&R) specialist may help resolve symptoms. Based on extrapolating studies on low back pain, it also would be prudent to consider a psychological evaluation of the patient prior to referral for surgery." Submitted documents did not correlate with the cited guideline a need for clearance from an internal medicine specialist. Thus, the request for clearance from an internal medicine specialist is not medically necessary.

PSYCHOLOGICAL EVALUATION: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Psychological Evaluations Page(s): 100-101.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Psychological evaluation Page(s): 100-101.

Decision rationale: The California Chronic Pain Medical Treatment Guidelines state, "Psychological evaluations are generally accepted, well-established diagnostic procedures not only with selected use in pain problems, but also with more widespread use in chronic pain populations. Diagnostic evaluations should distinguish between conditions that are preexisting, aggravated by the current injury or work related. Psychosocial evaluations should determine if further psychosocial interventions are indicated. The interpretations of evaluation should provide clinicians with a better understanding of the patient in their social environment, thus allowing for more effective rehabilitation." Submitted records, indicate the patient has numerous chronic conditions, of which, as noted by the provider, may require psychological attention. Therefore, the request for a psychological evaluation is medically necessary.

CAPSAICIN 0.025% / FLURBIPROFEN 20%/ TRAMADOL 10%/ CAMPHOR 2%/ MENTHOL 2% 240G QTY: 4.: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: The California Chronic Pain Medical Treatment Guidelines note, "Recommended as an option as indicated below. Largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. (Namaka, 2004) These agents are applied locally to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. (Colombo, 2006) Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, -adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor). (Argoff, 2006) There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. [Note: Topical analgesics work locally underneath the skin where they are applied. These do not include transdermal analgesics that are systemic agents entering the body through a transdermal means. See Duragesic (Fentanyl transdermal system).] "Reviews of submitted documents indicate the patient was not suffering from neuropathic pain when trials of antidepressants and anticonvulsants have failed and there is little to no research to support the use of many of these agents. Therefore, the request for Capsaicin 0.025% / Flurbiprofen 20%/ Tramadol 10%/ Camphor 2%/ Menthol 2% 240g Qty: 4 are not medically necessary.

FLURBIPROFEN 20%/ TRAMADOL 20% 240G QTY:4: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs / Opioids Page(s): 70-75.

Decision rationale: Regarding Flurbiprofen, the cited guidelines indicate, "Recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence to recommend one drug in this class over another based on efficacy. In particular, there appears to be no difference between traditional NSAIDs and COX-2 NSAIDs in terms of pain relief. The main concern of selection is based on adverse effects. COX-2 NSAIDs have fewer GI side effects at the risk of increased cardiovascular side effects, although the FDA has concluded that long-term clinical trials are best interpreted to suggest that cardiovascular risk occurs with all NSAIDs and is a class effect (with Naproxyn being the safest drug). There is no evidence of long-term effectiveness for pain or function." Submitted records indicate the patient had been on

NSAIDs for years. The guidelines recommend continuing with NSAIDs for such a long period of time. Therefore, the request for Flurbiprofen is not medically necessary. Regarding Tramadol, the cited guidelines note, "Tramadol (Ultram) is a centrally acting synthetic opioid analgesic and it is not recommended as a first-line oral analgesic. Central acting analgesics: an emerging fourth class of opiate analgesic that may be used to treat chronic pain. This small class of synthetic opioids (e.g., Tramadol) exhibits opioid activity and a mechanism of action that inhibits the reuptake of serotonin and norepinephrine. Central analgesics drugs such as Tramadol (Ultram) are reported to be effective in managing neuropathic pain. (Kumar, 2003) Side effects are similar to traditional opioids." Submitted records indicate the patient has been on several medications, of which combining with an opioid such as Tramadol would risk adverse affects. Thus, the request for Tramadol is not medically necessary at this time.