MAXIMUS Federal Services

Case Number:	CM14-0152046		
Date Assigned:	10/01/2014	Date of Injury:	03/16/2006
Decision Date:	11/20/2014	UR Denial Date:	08/20/2014
Priority:	Standard	Application Received:	09/18/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain 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:

This is a patient with a date of injury of 3/16/06. A utilization review determination dated 8/20/14 recommends non-certification of medial branch blocks, urine toxicology, oxycodone, zolpidem, cyclobenzaprine, gabapentin, and topical cream. Pristiq and testosterone level were certified. 7/11/14 medical report identifies previous facet and radiofrequency ablation with very good improvement of the symptoms. Pain has returned and goes to a level of 6-7/10. On exam, there is limited lumbar ROM with more pain on extension and rotation, positive facet loading, negative SLR, positive "Patrick Fabere's" bilaterally, more on the right. Decreased right knee ROM with positive McMurray. Recommendations include medial branch blocks to confirm the main pain generator prior to radiofrequency ablation, Pristiq, gabapentin, cyclobenzaprine, zolpidem, oxycodone, testosterone level study, and transdermal compound. UDS was performed 1/14 and 7/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar Diagnostic Differential Facet Block at Level of L4-5, L5-S1 Medial Branches Bilaterally: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Facet Joint Diagnostic blocks (injections)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, 309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Facet Joint Pain, Signs & Symptoms, Facet Joint Diagnostic Blocks (Injections), Facet Joint Medial Branch Blocks (Therapeutic)

Decision rationale: Regarding the request for Lumbar Diagnostic Differential Facet Block at Level of L4-5, L5-S1 Medial Branches Bilaterally, Chronic Pain Medical Treatment Guidelines state that invasive techniques are of questionable merit. ODG guidelines state that medial branch blocks may be indicated if there is tenderness to palpation in the paravertebral area, a normal sensory examination, and absence of radicular findings. Guidelines go on to recommend no more than 2 joint levels be addressed at any given time and recommend proceeding to radiofrequency ablation after successful medial branch blocks. Within the documentation available for review, it is noted that the patient previously underwent medial branch blocks and subsequent radiofrequency ablation with reportedly good improvement of symptoms. There is typically no need to repeat medial branch blocks after successful diagnosis and treatment of facet arthropathy with blocks and radiofrequency ablation. Rather, if radiofrequency ablation is successful and symptoms recur in the future, the supported protocol is to repeat that procedure. There is no clear rationale presented for repeating medial branch blocks in this patient. In the absence of such documentation, the currently requested Lumbar Diagnostic Differential Facet Block at Level of L4-5, L5-S1 Medial Branches Bilaterally are not medically necessary.

Urine Toxicology Screen: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids (screening for risk of addiction (test)/steps to avoid mis. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Urine Drug Testing (UDT)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 76-79; 99.

Decision rationale: Regarding the request for a urine toxicology test, CA MTUS Chronic Pain Medical Treatment Guidelines state the drug testing is recommended as an option. Guidelines go on to recommend monitoring for the occurrence of any potentially aberrant (or nonadherent) drug related behaviors. ODG recommends urine drug testing on a yearly basis for low risk patients, 2-3 times a year for moderate risk patients, and possibly once per month for high risk patients. Within the documentation available for review, it appears that a previous UDS was done approximately 6 months prior to the date of the request and there is no documentation of current risk stratification to identify the medical necessity of drug screening at the proposed frequency. There is no statement indicating why this patient would be considered to be high risk for opiate misuse, abuse, or diversion. In the absence of such documentation, the currently requested urine toxicology test is not medically necessary.

Oxycodone 10 MG 1 by mouth 2 Times A Day: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids (Criteria for Use/Ongoing Management).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 44, 47, 75-79, 120.

Decision rationale: Regarding the request for oxycodone, California Pain Medical Treatment Guidelines note that it 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, there is no indication that the medication is improving the patient's function or pain (in terms of specific examples of functional improvement and percent reduction in pain or reduced NRS), no documentation regarding side effects, and no discussion regarding aberrant use. As such, there is no clear indication for ongoing use of the medication. Opioids should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In light of the above issues, the currently requested oxycodone is not medically necessary.

Zolpidem 10 MG #60: 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), Pain Chapter, Zolpidem (Ambien)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) Chronic Pain, Sleep Medication

Decision rationale: Regarding the request for zolpidem, California MTUS guidelines are silent regarding the use of sedative hypnotic agents. ODG recommends the short-term use (usually two to six weeks) of pharmacological agents only after careful evaluation of potential causes of sleep disturbance. They go on to state the failure of sleep disturbances to resolve in 7 to 10 days, may indicate a psychiatric or medical illness. Within the documentation available for review, there are no subjective complaints of insomnia, no discussion regarding how frequently the insomnia complaints occur or how long they have been occurring, no statement indicating what behavioral treatments have been attempted for the condition of insomnia, and no statement indicating how the patient has responded to zolpidem treatment. Finally, there is no indication that Ambien is being used short-term as recommended by guidelines. In the absence of such documentation, the currently requested zolpidem is not medically necessary.

Cyclobenzaprine 5 MG 1 by mouth Every Night at Bedtime: 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 Page(s): 63-66.

Decision rationale: Regarding the request for cyclobenzaprine, Chronic Pain Medical Treatment Guidelines support the use of nonsedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Within the documentation available for review, there is no identification of a specific analgesic benefit or objective functional improvement as a result of the medication. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. In the absence of such documentation, the currently requested cyclobenzaprine is not medically necessary.

Pristiq 100mg #60: 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), Mental Illness and Stress Chapter, Desvenlafaxine (Pristiq)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13-16.

Decision rationale: Regarding the request for Pristiq, CA MTUS states that antidepressants are recommended as a 1st line option for neuropathic pain and as a possibility for non-neuropathic pain. Guidelines go on to recommend a trial of at least 4 weeks. Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in use of other analgesic medication, sleep quality and duration, and psychological assessment. Within the documentation available for review, there is no identification that the medication provides any specific analgesic effect (in terms of reduced numeric rating scale or percent reduction in pain), or provides any objective functional improvement, reduction in opiate medication use, or improvement in psychological wellbeing. In the absence of clarity regarding those issues, the currently requested Pristiq is not medically necessary.

Gabapentin 600mg, #60: 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 Page(s): 16-21.

Decision rationale: Regarding request for gabapentin, 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, there is no identification of any specific analgesic benefit (in terms of percent reduction in pain or reduction

of NRS), and no documentation of specific objective functional improvement. Additionally, there is no discussion regarding side effects from this medication. In the absence of such documentation, the currently requested gabapentin is not medically necessary.

Topical cream with Flurbiprofen and Cyclobenzaprine applied twice a day: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics.

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

Decision rationale: Regarding the request for topical cream with flurbiprofen and cyclobenzaprine, CA MTUS states that topical compound medications require guideline support for all components of the compound in order for the compound to be approved. Topical NSAIDs are indicated for "Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Neuropathic pain: Not recommended as there is no evidence to support use." Muscle relaxants are not supported by the CA MTUS for topical use. Within the documentation available for review, none of the abovementioned criteria have been documented. Furthermore, there is no clear rationale for the use of topical medications rather than the FDA-approved oral forms for this patient. Given all of the above, the requested topical cream with flurbiprofen and cyclobenzaprine is non-certified.