

Case Number:	CM14-0201253		
Date Assigned:	12/11/2014	Date of Injury:	01/13/2000
Decision Date:	01/27/2015	UR Denial Date:	12/01/2014
Priority:	Standard	Application Received:	12/02/2014

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 Family Practice and is licensed to practice in Ohio. 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 43-year-old female with a date of injury of January 13, 2000. She complains of cervical spine pain radiating to the left upper extremity with numbness, low back pain radiating to the left lower extremity with left foot numbness, and left shoulder pain. The physical examination reveals tenderness to palpation of the cervical spine, tenderness of the left shoulder, spasm of the lumbar paraspinal muscles, decreased sensation of the left dorsal foot, diminished strength of the left extensor hallucis longus muscle, positive lumbar facet signs, and a positive straight leg raise test on the left side. She has been treated with topical creams, naproxen 550 mg twice daily, omeprazole 20 mg daily, Neurontin 600 mg 3 times daily, and Flexeril 7.5 mg 3 times daily. While she is not reported to be taking any opioids, urine drug screens have been positive for opiates twice in the preceding year. The injured worker has had lumbar epidural steroid injections with 50% relief, the last occurring April 26, 2013. The diagnoses include lumbosacral radiculopathy, cervical radiculopathy, lumbar facet syndrome, history of left shoulder surgery, myofascial pain syndrome, lumbar sprain/strain, and cervical strain/strain. At issue is a request for 8 sessions of acupuncture, one urine drug screen, medial branch blocks bilaterally of L3, L4, L5, and S1, naproxen 550 mg #60, omeprazole 20 mg #30, Neurontin 600 mg #90, and Flexeril 7.5 mg #90. These requests were previously noncertified with the reviewer citing CA MTUS and ODG guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral L3,L4,L5,S1 medial branch blocks: 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), Low Back, Facet joint intra-articular injections (therapeutic blocks).

Decision rationale: Criteria for use of therapeutic intra-articular and medial branch blocks are as follows: 1. No more than one therapeutic intra-articular block is recommended. 2. There should be no evidence of radicular pain, spinal stenosis, or previous fusion. 3. If successful (initial pain relief of 70%, plus pain relief of at least 50% for a duration of at least 6 weeks), the recommendation is to proceed to a medial branch diagnostic block and subsequent neurotomy (if the medial branch block is positive). 4. No more than 2 joint levels may be blocked at any one time. 5. There should be evidence of a formal plan of additional evidence-based activity and exercise in addition to facet joint injection therapy. In this instance, the treating physician is requesting medial branch blocks at 4 levels. The guidelines only permit two levels at a time. Additionally, the injured worker has clear evidence of radicular pain confirmed by physical exam and previous positive response to epidural steroid injections. Therefore, bilateral L3, L4, L5, and S1 medial branch blocks are not medically necessary.

One prescription of Naproxen 550 mg # 60: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 68.

Decision rationale: NSAIDs such as naproxen are recommended as an option for short-term symptomatic relief of chronic low back pain. A Cochrane review of the literature on drug relief for low back pain (LBP) suggested that NSAIDs were no more effective than other drugs such as acetaminophen, narcotic analgesics, and muscle relaxants. The review also found that NSAIDs had more adverse effects than placebo and acetaminophen but fewer effects than muscle relaxants and narcotic analgesics. In addition, evidence from the review suggested that no one NSAID, including COX-2 inhibitors, was clearly more effective than another. For neuropathic pain, there is inconsistent evidence for the use of these medications to treat long-term neuropathic pain, but they may be useful to treat breakthrough and mixed pain conditions such as osteoarthritis (and other nociceptive pain) in with neuropathic pain.

One prescription of Omeprazole 20 mg # 30: Overturned

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic), NSAIDs, GI symptoms & cardiovascular risk.

Decision rationale: Proton pump inhibitors such as omeprazole are indicated to prevent gastrointestinal events if the patient has one or more of the following risk factors: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). A history of ulcer complications is the most important predictor of future ulcer complications associated with NSAID use. This instance, naproxen 550 mg twice daily is considered high dose NSAID therapy. Therefore, Omeprazole 20 mg #30 is medically necessary.

One prescription of Neurontin 600 mg # 90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anticonvulsants Page(s): 16-17.

Decision rationale: Anti-epilepsy drugs such as Neurontin are recommended for neuropathic pain (pain due to nerve damage). The choice of specific agents reviewed below will depend on the balance between effectiveness and adverse reactions. A "good" response to the use of AEDs has been defined as a 50% reduction in pain and a "moderate" response as a 30% reduction. It has been reported that a 30% reduction in pain is clinically important to patients and a lack of response of this magnitude may be the "trigger" for the following: (1) a switch to a different first-line agent (TCA, SNRI or AED are considered first-line treatment); or (2) combination therapy if treatment with a single drug agent fails. 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. AEDs are associated with teratogenicity, so they must be used with caution in woman of childbearing age. In this instance, there is no documentation provided that shows any meaningful benefit from the Neurontin so far prescribed. Consequently, Neurontin 600 mg # 90 is not medically necessary.

One prescription of Flexeril 7.5 mg # 90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 41-42.

Decision rationale: Cyclobenzaprine is a skeletal muscle relaxant and a central nervous system (CNS) depressant that is marketed as Flexeril by Ortho McNeil Pharmaceutical. Flexeril is recommended as an option for pain, using a short course of therapy. Cyclobenzaprine (Flexeril)

is more effective than placebo in the management of back pain; the effect is modest and comes at the price of greater adverse effects. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. Treatment should be brief. In this instance, it appears that cyclobenzaprine has been in continuous use for at least 5 months thereby exceeding recommendations for a short course of therapy. Consequently, Flexeril 7.5 mg # 90 is not medically necessary.

8 Sessions of Acupuncture: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic), Acupuncture.

Decision rationale: ODG Acupuncture Guidelines: Initial trial of 3-4 visits over 2 weeks with evidence of reduced pain, medication use and objective functional improvement, total of up to 8-12 visits over 4-6 weeks (Note: The evidence is inconclusive for repeating this procedure beyond an initial short course of therapy.) In this instance, it appears that the worker has not yet had acupuncture and therefore an initial trial is the default recommendation. The request for 8 acupuncture visits without an initial trial exceeds that which is recommended by the guidelines. Therefore, 8 sessions of acupuncture is not medically necessary.

One Urine Drug Screen: Overturned

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic), Urine Drug Testing.

Decision rationale: Urine drug testing is recommended as a tool to monitor compliance with prescribed substances, identify use of undisclosed substances, and uncover diversion of prescribed substances. The test should be used in conjunction with other clinical information when decisions are to be made to continue, adjust or discontinue treatment. This information includes clinical observation, results of addiction screening, pill counts, and prescription drug monitoring reports. The prescribing clinician should also pay close attention to information provided by family members, other providers and pharmacy personnel. Indications for UDT: 1) UDT is recommended at the onset of treatment of a new patient who is already receiving a controlled substance or when chronic opioid management is considered. Urine drug testing is not generally recommended in acute treatment settings (i.e. when opioids are required for nociceptive pain). (2) In cases in which the patient asks for a specific drug. This is particularly the case if this drug has high abuse potential, the patient refuses other drug treatment and/or changes in scheduled drugs, or refuses generic drug substitution. (3) If the patient has a positive

or "at risk" addiction screen on evaluation. This may also include evidence of a history of comorbid psychiatric disorder such as depression, anxiety, bipolar disorder, and/or personality disorder. (4) If aberrant behavior or misuse is suspected and/or detected. If a patient has evidence of a "high risk" of addiction (including evidence of a comorbid psychiatric disorder (such as depression, anxiety, attention-deficit disorder, obsessive-compulsive disorder, bipolar disorder, and/or schizophrenia), has a history of aberrant behavior, personal or family history of substance dependence (addiction), or a personal history of sexual or physical trauma, ongoing urine drug testing is indicated as an adjunct to monitoring along with clinical exams and pill counts. Those at high risk of addiction may have urine drug testing as frequently as once a month. In this instance, the injured worker has had two urine drug tests within the previous calendar year which each tested positive for opiates in spite of the treating physician not having given a prescription for opiates. This would place the injured worker solidly in a high risk of addiction category. Consequently, one Urine Drug Screen is medically necessary.