

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM15-0004536 | | |
| Date Assigned: | 01/16/2015 | Date of Injury: | 11/30/2000 |
| Decision Date: | 03/18/2015 | UR Denial Date: | 12/30/2014 |
| Priority: | Standard | Application Received: | 01/09/2015 |

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: North Carolina

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 67 year old female, who sustained an industrial injury on November 30, 2000. She has reported neck pain, low back pain and bilateral knee pain. The diagnoses have included myofascial pain syndrome, lumbar spinal stenosis and shoulder and upper arm sprain/strain. Treatment to date has included knee replacement, spinal discectomy and fusion, epidural steroid injection, physical therapy, transdermal medication and oral medication. Currently, the IW complains of increased pain in neck and shoulders and feeling of bubbles in her low back. Treatment includes oral and topical medication, heat and rest. On December 30, 2014 utilization review non-certified a request for bilateral C4-C7 medial branch block, sleep study and Nucynta ER 200mg noting lack of documentation to support medical necessity. The Medical Treatment Utilization Schedule (MTUS) and Official Disability Guidelines (ODG) were utilized in the determination. Application for independent medical review (IMR) is dated January 9, 2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral C4-C7 Medial Branch Block: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck & Upper Back Chapter, Facet joint diagnostic block

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation facet medial branch blocks

Decision rationale: The ACOEM states: Invasive techniques (e.g., local injections and facet-joint injections of cortisone and lidocaine) are of questionable merit. Although epidural steroid injections may afford short-term improvement in leg pain and sensory deficits in patients with nerve root compression due to a herniated nucleus pulposus, this treatment offers no significant long term functional benefit, nor does it reduce the need for surgery. Despite the fact that proof is still lacking, many pain physicians believe that diagnostic and/or therapeutic injections may have benefit in patients presenting in the transitional phase between acute and chronic pain. Per the ODG, facet joint injections are under study. Current evidence is conflicting as to this procedure and at this time no more than one therapeutic intra-articular block is suggested. Intra-articular facet joint injections have been popularly utilized as a therapeutic procedure, but are currently not recommended as a treatment modality in most evidence based reviews as their benefit remains controversial. Criteria for use of diagnostic blocks for facet nerve pain: 1. One set of diagnostic medial branch blocks is required with a response of 70% 2. Limited to non-radicular cervical pain and no more than 2 levels bilaterally. 3. Documentation of failure of conservative therapy 4. No more than 2 joint levels are injected in 1 session 5. Diagnostic facet blocks should be performed in patients whom a surgical procedure is anticipated. The requested service is not recommended per the ACOEM or the Official Disability Guidelines. When recommended, no more than 2 joint levels at a time are recommended. The request is for multiple levels. Therefore criteria have not been met and the requests is not certified.

Sleep Study: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Polysomnography

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Up-to Date guidelines

Decision rationale: The California MTUS, ODG and the ACOEM do not specifically address the requested service. Per the up-to-date medical guidelines, sleep studies are indicated in the evaluation of sleep apnea. This patient has no indication of sleep apnea symptoms in the provided documentation. The reason for the testing is because of the high dose of opioids the patient is taking. This is not an indication for a sleep study. Therefore the request is not medically warranted and is denied.

Nucynta ER 200mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids
Page(s): 76-84.

Decision rationale: The California chronic pain medical treatment guidelines section on opioids states for ongoing management: On-Going Management. Actions Should Include: (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy.(b) The lowest possible dose should be prescribed to improve pain and function.(c) Office: 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. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. (Passik, 2000)(d) Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain diary that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management. (e) Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control.(f) Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion). (g) Continuing review of overall situation with regard to nonopioid means of pain control.(h) 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 does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consult if there is evidence of substance misuse. When to Continue Opioids (a) If the patient has returned to work (b) If the patient has improved functioning and pain(Washington, 2002) (Colorado, 2002) (Ontario, 2000) (VA/DoD, 2003) (Maddox-AAPM/APS, 1997) (Wisconsin, 2004) (Warfield, 2004) The long-term use of this medication class is not recommended per the California MTUS unless there documented evidence of benefit with measurable outcome measures and improvement in function. There is no documentation of subjective improvement in pain such as VAS scores. There is also no objective measure of improvement in function. The documentation simply states the patient can do ADs with the medication. For these reasons the criteria set forth above of ongoing and continued used of opioids have not been met. Therefore the request is not certified.