

<b>Case Number:</b>	CM15-0102985		
<b>Date Assigned:</b>	06/05/2015	<b>Date of Injury:</b>	01/24/2003
<b>Decision Date:</b>	07/09/2015	<b>UR Denial Date:</b>	05/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/28/2015

### 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: New York  
 Certification(s)/Specialty: Anesthesiology

### 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 40 year old male who sustained an industrial injury on 01/24/2003. Current diagnosis includes lumbago lumbar radiculopathy. Previous treatments included medications, physical therapy, and home exercises. Report dated 04/29/2015 noted that the injured worker presented with complaints that included pain in the lower back with radiation into both legs. Other complaints included constipation, depression secondary to pain, numbness, tingling, and weakness. Pain level was 6 out of 10 on a visual analog scale (VAS) with medications. Physical examination was positive for slowed gait, muscle spasms, tenderness, positive straight leg raise test, and decreased sensation in the L5-S1 distribution. The treatment plan included refilling medications, continue home exercises, and request for extension for the ortho consultation. Disputed treatments include 1 transforaminal lumbar epidural injection to the left L5-S1, Trazodone, Oxycodone HCL, Fentanyl, Amitiza, and gabapentin.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Transforaminal Lumbar Epidural Injection to the Left L5-S1: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
ESIs Page(s): 46.

**Decision rationale:** A selective nerve root block, or transforaminal epidural steroid injection (ESI), is a variation of the traditional midline ESI; the spinal nerve roots exit the spine laterally. Based on a patient's medical history, a physical exam, and MRI findings, often a specific inflamed nerve root can be identified. According to the CA MTUS guidelines, criteria for ESI's include the following: radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electro-diagnostic testing; initially unresponsive to conservative treatment; and no more than two nerve root levels should be injected using transforaminal blocks. Repeat blocks should only be offered if there is at least 50-70% pain relief for six to eight weeks following previous injection, with a general recommendation of no more than 4 blocks per region per year. In this case, there is no documentation of imaging studies or electrodiagnostic testing to corroborate the patient's radiculopathy. Therefore, medical necessity for the requested left L5-S1 transforaminal ESI has not been established. The requested injection is not medically necessary.

**Trazodone 50 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), Mental Illness and Stress.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Insomnia treatment.

**Decision rationale:** Trazodone (Desyrel) is recommended as an option for insomnia, only for patients with potentially coexisting mild psychiatric symptoms such as depression or anxiety. It is unrelated to tricyclic or tetracyclic antidepressants and has some action as an anxiolytic. In this case, there is no documentation of a history of depression, anxiety or insomnia. Medical necessity of the requested medication has not been established. The requested medication is not medically necessary.

**Oxycodone HCL 15 MG #180:**  
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): 91-97. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

**Decision rationale:** According to ODG and MTUS, Oxycodone (Oxycontin) is a long-acting opioid analgesic. Opioid drugs are available in various dosage forms and strengths. They are

considered the most powerful class of analgesics. According to the ODG, chronic pain can have a mixed physiologic etiology of both that may be used to manage both acute and chronic pain. These medications are generally classified according to potency and duration of dosage. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, there is no documentation of the medication's pain relief effectiveness, functional improvement from previous usage, or response to ongoing opiate therapy. Medical necessity of the requested item has not been established. Of note, discontinuation of an Oxycodone should include a taper, to avoid withdrawal symptoms. The requested medication is not medically necessary.

### **Fentanyl 50 MCG/HR Patches #10: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 91-97. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

**Decision rationale:** Fentanyl is an opioid analgesic with a potency of eighty times that of Morphine. According to ODG, chronic pain can have a mixed physiologic etiology of both neuropathic and nociceptive components. In most cases, analgesic treatment should begin with acetaminophen, aspirin, and NSAIDs. According to ODG and MTUS, Fentanyl is a long-acting narcotic analgesic used to manage both acute and chronic pain. Fentanyl transdermal (Duragesic) patches are indicated for the management of persistent chronic pain, which is moderate to severe requiring continuous, around-the-clock opioid therapy. Duragesic patches should only be used in patients who are currently on opioid therapy for which tolerance has developed. Patches are worn for a 72-hour period. In this case, the treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. There is no documentation of the medication's pain relief effectiveness, functional status, or response to ongoing opioid analgesic therapy. Medical necessity of the requested item has not been established. Of note, discontinuation of an opioid analgesic should include a taper to avoid withdrawal symptoms. The requested medication is not medically necessary.

### **Amitiza 8 MCG #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).

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

**Decision rationale:** Opioid-induced constipation is a common adverse effect of long-term opioid use because of the binding of opioids to peripheral opioid receptors in the gastrointestinal tract, resulting in absorption of electrolytes and reduction in small intestine fluid. According to ODG, if opioids are determined to be appropriate for the treatment of pain then prophylactic treatment of constipation should be initiated. ODG states that Amitiza is recommended for the treatment of constipation only if first-line treatments for opioid-induced constipation have failed. In this case, there is no documentation of constipation. Medical necessity for the requested medication has not been established. The requested medication is not medically necessary.

**Gabapentin 300 MG #30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs) Page(s): 17-19.

**Decision rationale:** According to the CA MTUS (2009) and ODG, Neurontin (Gabapentin) is an anti-epilepsy drug, which has been considered a first-line treatment for neuropathic pain. The records do not document that the patient has neuropathic pain related to his chronic low back condition. In this case, there was documentation indicating that the patient's pain escalated with Gabapentin usage. The guidelines recommend a switch to another anti-epilepsy drug or weaning Gabapentin. Medical necessity for Gabapentin has not been established. The requested medication is not medically necessary.