

<b>Case Number:</b>	CM15-0108463		
<b>Date Assigned:</b>	06/15/2015	<b>Date of Injury:</b>	05/03/1994
<b>Decision Date:</b>	07/14/2015	<b>UR Denial Date:</b>	05/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/05/2015

### 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 Jersey, Alabama, California  
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

### 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 62-year-old male, with a reported date of injury of 05/03/1994. The diagnoses include low back pain, lumbar disc herniation, lumbar failed back surgery syndrome, status post three lumbar surgeries, and lumbar degenerative disc disease. Treatments to date have included oral medication; an MRI of the lumbar spine on 03/31/2015 which showed previous laminectomy and fusion at L4-5 and L5-S1; transforaminal epidural steroid injection on 02/25/2014 of the left L3; and initial medial branch block at L2-3 bilaterally on 11/05/2013, without significant improvement. The medical report dated 04/22/2015 indicates that the injured worker continued to have back pain and a recent onset of left lower extremity radicular symptoms and intermittent pain. He reported that he was still getting good benefit from Avinza every twenty-four hours. The urine drug screens dated 02/19/2015 and 03/25/2015 were positive for high-level Morphine which was appropriate. A physical examination showed no gross axial deformities, and unremarkable postural examination in the sagittal and coronal planes. The treatment plan includes follow-up with the injured worker in twenty-eight days. The treating physician requested Avinza 75mg #28 and a medial branch block at L3-4 to diagnose facetogenic lumbar pain.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Avinza 75mg quantity 28:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of opioids Page(s): 179.

**Decision rationale:** According to MTUS guidelines, ongoing use of opioids should follow specific rules: (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. Avinza is a long-acting opioid, and highly potent form of opiate analgesic. The proposed advantage of long-acting opioids is that they stabilize medication levels, and provide around-the-clock analgesia. There is no clear evidence and documentation from the patient's file, of a continuous need for Avinza. There is no documentation of positive functional improvement. The patient still have severe pain. Therefore, the prescription of Avinza 75mg #28 is not medically necessary.

**Medial Branch Block at L3-L4:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

**Decision rationale:** According MTUS guidelines, 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. According to ODG guidelines regarding facets injections, Under study. Current

evidence is conflicting as to this procedure and at this time, no more than one therapeutic intra-articular block is suggested. If successful (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). If a therapeutic facet joint block is undertaken, it is suggested that it be used in consort with other evidence based conservative care (activity, exercise, etc.) to facilitate functional improvement. (Dreyfuss, 2003) (Colorado, 2001) (Manchikanti, 2003) (Boswell, 2005) See Segmental rigidity (diagnosis). In spite of the overwhelming lack of evidence for the long-term effectiveness of intra-articular steroid facet joint injections, this remains a popular treatment modality. Intra-articular facet joint injections have been popularly utilized as a therapeutic procedure, but are not currently recommended as a treatment modality in most evidence-based reviews as their benefit remains controversial. Furthermore and according to ODG guidelines, 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. In this case, there is no clear evidence that lumbar facets are the main pain generator. The diagnosis of radiculopathy or spinal stenosis was not fully excluded in this case. In addition, the patient did not attempt any conservative care, beside medication. Therefore, the request for Medial Branch Block at L3-L4 is not medically necessary.