

<b>Case Number:</b>	CM15-0199783		
<b>Date Assigned:</b>	10/15/2015	<b>Date of Injury:</b>	01/18/2008
<b>Decision Date:</b>	11/24/2015	<b>UR Denial Date:</b>	09/18/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/12/2015

### 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: Montana, Oregon, Idaho  
 Certification(s)/Specialty: Orthopedic Surgery

### 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 67 year old male sustained an industrial injury on 1-18-08. Documentation indicated that the injured worker was receiving treatment for chronic pain syndrome with low back and neck pain. In an appeal to denial of treatment dated 9-10-15, documentation indicated that the injured worker had sustained injuries to his neck, shoulders, wrist, upper and lower back, left knee and left heel. Previous treatment included bilateral carpal tunnel release, injections, left knee surgery (2008), chiropractic therapy, acupuncture, physical therapy and medications. The injured worker reported having impaired sleep due to pain. The physician documented that the injured worker was currently taking Norco, anti-hypertensive agents, diabetic agents and clonazepam. Past medical history was significant for hypertension and diabetes mellitus. In the only other documentation submitted for review, a PR-2 dated 8-27-15, subjective complaints were documented as "low back pain and neck pain". Physical exam was remarkable for "lumbar paraspinal tenderness and positive bilateral facet loading". The treatment plan included requesting authorization for bilateral L3-L4, L4-L5 and L5-S1 facet injections, Norco 10-325 four times a day, Gabapentin 300mg three times a day and pain creams. On 9-18-15, Utilization Review noncertified a request for bilateral L3-4, L4-5 and L5-S1 facet injections, Norco 10-325mg #120 and Gabapentin 300mg #90.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Bilateral L3-L4, L4-L5 and L5-S1 facet injections: 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), Low Back Chapter, Facet joint intra-articular injections (therapeutic blocks).

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back.

**Decision rationale:** According to the CA MTUS ACOEM Low Back Chapter, page 309, facet joint injections of the lumbar spine are not recommended, The ODG Low Back Complaints Section recommend no more than one set of medial branch diagnostic blocks prior to facet neurotomy, if neurotomy is chosen as an option for treatment (a procedure that is still considered "under study"). Diagnostic blocks may be performed with the anticipation that if successful, treatment may proceed to facet neurotomy at the diagnosed levels. Current research indicates that a minimum of one diagnostic block be performed prior to a neurotomy, and that this be a medial branch block (MBB). Criteria for the use of diagnostic blocks for facet "mediated" pain: Clinical presentation should be consistent with facet joint pain, signs & symptoms. 1. One set of diagnostic medial branch blocks is required with a response of 70%. The pain response should last at least 2 hours for Lidocaine. 2. Limited to patients with low-back pain that is non-radicular and at no more than two levels bilaterally. 3. There is documentation of failure of conservative treatment (including home exercise, PT and NSAIDs) prior to the procedure for at least 4-6 weeks. 4. No more than 2 facet joint levels are injected in one session (see above for medial branch block levels). 5. Recommended volume of no more than 0.5 cc of injectate is given to each joint. 6. No pain medication from home should be taken for at least 4 hours prior to the diagnostic block and for 4 to 6 hours afterward. 7. Opioids should not be given as a "sedative" during the procedure. 8. The use of IV sedation (including other agents such as midazolam) may be grounds to negate the results of a diagnostic block, and should only be given in cases of extreme anxiety. 9. The patient should document pain relief with an instrument such as a VAS scale, emphasizing the importance of recording the maximum pain relief and maximum duration of pain. The patient should also keep medication use and activity logs to support subjective reports of better pain control. 10. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated. (Resnick, 2005) 11. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. In this case, the request is facet injection at three different levels, which is not recommended by the guidelines. In addition, the documentation submitted does not support that the injured worker has had and failed a trial of conservative management. Therefore, the request does not meet the cited guidelines and is not medically necessary.

**Norco 10/325mg #120: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain, Opioids, long-term assessment. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain.

**Decision rationale:** According to the CA MTUS/Chronic Pain Medical Treatment Guidelines, page 80, opioids. A therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Opioids may be continued if the patient has returned to work and the patient has improved functioning and pain. Guidelines recommend 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. The ODG-TWC pain section comments specifically on criteria for the use of drug screening for ongoing opioid treatment. Based upon the records from 8/20/15 and 8/27/15 there is insufficient evidence to support chronic use of narcotics. There is lack of demonstrated functional improvement, percentage of relief, demonstration of urine toxicology compliance or increase in activity from the exam note from 8/27/15. Therefore, the request does not meet the criteria set forth in the guidelines and is not medically necessary.

**Gabapentin 300mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs).

**Decision rationale:** Per the CA MTUS Chronic Pain Treatment Guidelines page 18, Specific Anti-Epilepsy Drugs, Neurontin is indicated for diabetic painful neuropathy and postherpetic neuralgia and is considered first line treatment for neuropathic pain. 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. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects. In this case, the exam notes from 8/20/15 or 8/27/15 do not demonstrate evidence neuropathic pain (the 8/27/15 note documents low back and neck pain). In addition, the documentation does not demonstrate percentage of relief, the duration of relief, increase in function or increased activity. Therefore, the criteria set forth in the guidelines have not been met and the request is not medically necessary.