

Case Number:	CM15-0030782		
Date Assigned:	02/24/2015	Date of Injury:	02/09/2007
Decision Date:	04/09/2015	UR Denial Date:	02/06/2015
Priority:	Standard	Application Received:	02/18/2015

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: Pennsylvania
 Certification(s)/Specialty: Internal 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 was a 64 year old female, who sustained an industrial injury on February 9, 2007. Diagnoses include chronic back pain/failed back syndrome status post lumbar surgery, lumbar radiculitis, lumbar facet arthropathy, lumbar myofascial strain, lumbar stenosis, and lumbar degenerative disc disease, as well as right knee osteoarthritis and medial meniscus tear. The injured worker underwent bariatric surgery in May 2014. The injured worker previously received the following treatment: pain management consultation, medications, aqua aerobics, cane, low back brace, epidural steroid injections, sacroiliac joint injection, posterior/anterior interbody fusion at L2-L3, L3-L4, L4-L5 and L5-S1 on October 11, 2011, irrigation and debridement of postoperative wound infection on 10/26/11, hardware removal in March 26, 2013, acupuncture, chiropractic treatment, treatment by a pain psychologist, electrical stimulation, physical therapy, and home exercises. The injured worker has been prescribed hydrocodone and muscle relaxants since 2002 and tramadol since 2009. Computed tomography scan of the lumbosacral spine on 8/26/14 showed degenerative disc disease and facet arthropathy with S shaped thoracolumbar scoliosis and grade 1 anterolisthesis L5-S1, canal stenosis, neural foraminal narrowing, sacroiliac degenerative changes noted with the fusion on the left. EMG/NCS (electromyography and nerve conduction studies) of lower extremities on 6/19/14 showed evidence of L4 radiculopathy. A urine drug screen on 11/25/14 collected at an office visit was described as consistent with history, with no signs of aberrant behavior with medications prescribed. Examination on 12/23/14 showed normal and symmetric reflexes, intact sensation of dermatomes C2-S2, 5/5 muscle strength in upper and lower extremities, normal gait,

positive facet loading left greater than right, negative Faber's, Gaenslen's, and Waddell's testing. According to progress note of January 7, 2015, the injured worker's chief complaint was back and left leg complaints. The injured worker described the pain as constant dull, numb, sharp, and stabbing, greater on the right than the left. She rated the pain 6 out of 10 in severity. The physical exam noted decreased range of motion of the lumbar spine with sciatic notch tenderness, positive straight leg raising on the right, and diminished reflexes bilaterally. She reported that tramadol did not provide relief of pain in the past. Work status was noted as permanent and stationary. A progress note of 10/27/14 documents that the injured worker last worked on 3/16/11. On December 23, 2014, the primary treating physician requested authorization for bilateral medial branch block L4-L5, L5-S1 for facet arthropathy, Norco 5/325mg #90 for severe pain as the injured worker could not tolerate nonsteroidal anti-inflammatory agents (NSAIDs) secondary to history of bariatric surgery, Prilosec 20mg two times a day #60 to assist with medication tolerance given history of bariatric surgery, Norflex #60 for muscle spasm, Zanaflex 4mg #30 for muscle spasm, Urine drug screen, retroactive Ketoprofen cream for paraspinal pain and retroactive Ultracet 37.5mg #60 to augment pain relief. On February 6, 2015, the Utilization Review denied authorization for bilateral medial branch block L4-L5, L5-S1, Prilosec 20mg two times a day #60, Norflex #60, Zanaflex 4mg #30, Urine drug screen, retroactive Ketoprofen cream and retroactive Ultracet 37.5mg #60. Utilization review modified a request for Norco 5/325mg #90 to #30. Utilization Review cited the MTUS/ACOEM and ODG guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral Medical Branch Block L4-5, L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chronic Pain Treatment Guidelines Diagnostic blocks for facet "medicated" pain. Decision based on Non-MTUS Citation Official Disability Guidelines; Lumbar Facet injections; (http://www.odg-twc.com/odgtwc/low_back.htm).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): p. 300, 309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back chapter: facet joint medial branch blocks.

Decision rationale: Per the ACOEM low back chapter, facet joint injections are of questionable merit, but 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 table 12-8 in the ACOEM low back chapter, facet joint injections are categorized as not recommended due to limited research-based evidence. The ODG states that facet joint medial branch blocks are not recommended except as a diagnostic tool. The ODG notes that no more than one set of medial branch diagnostic blocks are recommended prior to facet neurotomy, and that diagnostic blocks may be performed with the anticipation that if successful, treatment may proceed to facet neurotomy at the diagnosed levels. The ODG notes criteria for use of diagnostic facet joint blocks include limiting use to patients with low back pain that is non-radicular and at no more than two levels bilaterally, documentation of failure of conservative treatment including home

exercise, physical therapy, and non-steroidal anti-inflammatory medication prior to the procedure for at least 4-6 weeks, and no more than 2 facet joint levels injected at one session. The Official Disability Guidelines recommend against medial branch blocks for patients with radiculopathy. As noted in the MTUS, all treatment for chronic pain should have as its goal functional improvement, not cure of pain. A treatment plan which does not describe specific plans for functional improvement is not adequate for treatment of chronic pain. This injured worker was noted to have radiculopathy. There were insufficient findings to support facet arthropathy, and no plans for facet neurotomy were discussed. The injured worker was noted to be permanent and stationary and it was documented that she had not worked since March 2011, and no functional goals were discussed. Due to presence of radiculopathy, insufficient findings of facet arthropathy with plans for facet neurotomy, and lack of functional goals, the request for Bilateral Medical Branch Block L4-5, L5-S1 is not medically necessary.

Norco 5/325 #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Hydrocodone/Acetaminophen; Short-acting opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids
Page(s): p. 74-96.

Decision rationale: There is no evidence that the treating physician is prescribing opioids according to the MTUS, which recommends prescribing according to function, with specific functional goals, return to work, random drug testing, and opioid contract. There should be a prior failure of non-opioid therapy. None of these aspects of prescribing are in evidence. Per the MTUS, opioids are minimally indicated, if at all, for chronic non-specific pain, osteoarthritis, "mechanical and compressive etiologies," and chronic back pain. There is no evidence of significant pain relief or increased function from the opioids used to date. The injured worker has been prescribed opiates including hydrocodone since 2002, and she has not worked since 2011. The prescribing physician does not specifically address function with respect to prescribing opioids, and does not address the other recommendations in the MTUS. The MTUS states that a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. There is no evidence that the treating physician has utilized a treatment plan NOT using opioids, and that the patient "has failed a trial of non-opioid analgesics." Ongoing management should reflect four domains of monitoring, including analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors. The documentation does not reflect improvement in pain. Changes in activities of daily living were not documented. There was no documentation of functional improvement as a result of use of norco. The injured worker is not working, and there has been no reduction in use of medications or decrease in frequency of office visits. The MTUS recommends urine drug screens for patients with poor pain control and to help manage patients at risk of abuse. There is no record of a urine drug screen program performed according to quality criteria in the MTUS and other guidelines. One urine drug screen was described in November 2014 and was performed at an office visit, not randomly as advised by the guidelines. As currently prescribed, norco does not meet the criteria for long term opioids as elaborated in the MTUS and is therefore not medically necessary.

Prilosec 20mg bid #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs): NSAIDs, GI symptoms & cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms and cardiovascular risk Page(s): 68-69.

Decision rationale: The MTUS states that co-therapy with a non-steroidal anti-inflammatory medication (NSAID) and a proton pump inhibitor (PPI) is not indicated in patients other than those at intermediate or high risk for gastrointestinal events (including age > 65 years, history of peptic ulcer, gastrointestinal (GI) bleeding or perforation, concurrent use of aspirin, corticosteroids and/or an anticoagulant, or high dose/multiple NSAIDS such as NSAID plus low dose aspirin). Long term proton pump inhibitor (PPI) use (> 1 year) has been shown to increase the risk of hip fracture. There was no mention of GI signs or symptoms. No abdominal examination was documented. The physician documented that prilosec was prescribed to assist with medication tolerance secondary to history of bariatric surgery. It was noted that the injured worker could not take NSAIDs due to history of bariatric surgery. Due to lack of indication, the request for prilosec is not medically necessary.

Norflex #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants: Antispasmodics (Norflex/Orphenadrine).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines muscle relaxants Page(s): p. 63-66.

Decision rationale: The MTUS for chronic pain does not recommend muscle relaxants for chronic pain. Non-sedating muscle relaxants are an option for short-term exacerbations of chronic low back pain. The muscle relaxant prescribed in this case is sedating. The injured worker has chronic pain with no evidence of prescribing for flare-ups. The quantity prescribed implies long term use, not for a short period of use for acute pain. No reports show any specific and significant improvement in pain or function as a result of prescribing muscle relaxants. Various muscle relaxants have been prescribed for more than 10 years. Orphenadrine (Norflex) is similar to diphenhydramine, but with greater anticholinergic effects; the mode of action is not clearly understood and effects are thought to be secondary to analgesic and anticholinergic properties. Side effects include drowsiness, urinary retention, and dry mouth; it has been reported in case studies to be abused for euphoria and to have mood elevating effects. The treating physician has prescribed another muscle relaxant (zanaflex) which is duplicative and potentially toxic. Due to long term use not in accordance with the guidelines and lack of functional improvement as a result of use of muscle relaxants, the request for norflex is not medically necessary.

Zanaflex 4 mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants: Tizanidine (Zanaflex).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines muscle relaxants Page(s): p. 63-66.

Decision rationale: The MTUS for chronic pain does not recommend muscle relaxants for chronic pain. Non-sedating muscle relaxants are an option for short-term exacerbations of chronic low back pain. The muscle relaxant prescribed in this case is sedating. The injured worker has chronic pain with no evidence of prescribing for flare-ups. The quantity prescribed implies long term use, not for a short period of use for acute pain. No reports show any specific and significant improvement in pain or function as a result of prescribing muscle relaxants. Muscle relaxants have been prescribed for more than 10 years. Tizanidine (Zanaflex) is FDA approved for management of spasticity and unlabeled for use for low back pain. Side effects include somnolence, dizziness, dry mouth, hypotension, weakness, and hepatotoxicity. Liver function tests should be monitored. It should be used with caution in renal impairment and avoided in hepatic impairment. There is no documentation that laboratory tests are being monitored. The treating physician has prescribed another muscle relaxant (norflex) which is duplicative and potentially toxic. Due to long term use not in accordance with the guidelines, lack of functional improvement as a result of use of muscle relaxants, and potential for toxicity, the request for zanaflex is not medically necessary.

Urine drug screen: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines On-going Management of Opioid use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines drug testing p. 43, opioids p. 77- 78, p. 89, p. 94 Page(s): 43, 77-78, 89, 94. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) chronic pain chapter: urine drug testing.

Decision rationale: Per MTUS chronic pain medical treatment guidelines, urine drug screens are recommended as an option to assess for the use or the presence of illegal drugs, in accordance with a treatment plan for use of opioid medication, and as a part of a pain treatment agreement for opioids. Per the ODG, 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. Urine drug testing is recommended at the onset of treatment when chronic opioid management is considered, if the patient is considered to be at risk on addiction screening, or if aberrant behavior or misuse is suspected or detected. Ongoing monitoring is recommended if a patient has evidence of high risk of addiction and with certain clinical circumstances. Frequency of urine drug testing should be based on risk stratification. Patients with low risk of addiction/aberrant behavior should be tested within six months of initiation of therapy and on a yearly basis thereafter. Patients at moderate risk for addiction/aberrant behavior should be tested 2-3 times per year. Patients at high risk of adverse outcomes may require testing as often as once a month. Random collection is recommended. Results of testing should be documented and addressed. The injured worker has been prescribed

opioids for more than 10 years, and the current requests for opioids have been determined to be not medically necessary. Only one urine drug screen was discussed in the documentation provided, and specific results were not submitted. This prior test from November 2014 was performed at an office visit, whereas the guidelines recommend random testing. There was no documentation of risk of addiction or aberrant behavior to warrant another urine drug screen at this time. Due to lack of continued necessity of opioid treatment, and frequency of urine drug screening requested not in accordance with the guidelines, the request for urine drug screen is not medically necessary.

Ketoprofen Cream: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ketoprofen: topical analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines: Topical medications; <http://www.odg-twc.com/odgtwc/pain.htm#Topicalanalgesics>).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): p. 111-113.

Decision rationale: Per the MTUS, topical analgesics are recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Ketoprofen, a nonsteroidal anti-inflammatory agent (NSAID), is not currently FDA approved for topical application. It has a high incidence of photocontact dermatitis. There is little evidence to utilize topical NSAIDS for treatment of osteoarthritis of the spine, hip, or shoulder, and topical NSAIDS are not recommended for neuropathic pain. As topical ketoprofen is not FDA approved, it is therefore experimental and cannot be presumed as safe and efficacious. Non-FDA approved medications are not medically necessary. For these reasons the request for ketoprofen cream is not medically necessary.

Ultracet 37.5 mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultracet, Ultram) synthetic opioid.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): p. 74-96.

Decision rationale: There is no evidence that the treating physician is prescribing opioids according to the MTUS, which recommends prescribing according to function, with specific functional goals, return to work, random drug testing, and opioid contract. There should be a prior failure of non-opioid therapy. None of these aspects of prescribing are in evidence. Per the MTUS, opioids are minimally indicated, if at all, for chronic non-specific pain, osteoarthritis, "mechanical and compressive etiologies," and chronic back pain. There is no evidence of significant pain relief or increased function from the opioids used to date. Opioids have been prescribed since 2002 and tramadol has been prescribed since 2009. The documentation from the physician notes that tramadol did not provide relief of pain in the past. The injured worker has not worked since 2011, and there was no documentation of decrease in medication use or

decrease in frequency of office visits. The prescribing physician does not specifically address function with respect to prescribing opioids, and does not address the other recommendations in the MTUS. The MTUS states that a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. There is no evidence that the treating physician has utilized a treatment plan NOT using opioids, and that the patient "has failed a trial of non-opioid analgesics." Ongoing management should reflect four domains of monitoring, including analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors. The documentation does not reflect improvement in pain. Changes in activities of daily living were not documented. The MTUS recommends urine drug screens for patients with poor pain control and to help manage patients at risk of abuse. There is no record of a urine drug screen program performed according to quality criteria in the MTUS and other guidelines. As currently prescribed, tramadol does not meet the criteria for long term opioids as elaborated in the MTUS and is therefore not medically necessary.