

Case Number:	CM15-0055271		
Date Assigned:	03/30/2015	Date of Injury:	06/13/2007
Decision Date:	07/10/2015	UR Denial Date:	03/16/2015
Priority:	Standard	Application Received:	03/23/2015

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 is a 61-year-old male who sustained an industrial injury on 06/13/2007. Diagnoses include cervical radiculitis, status post cervical fusion, lumbar facet arthropathy, lumbar radiculopathy, anxiety, chronic pain, and bilateral ulnar nerve neuropathy. Treatment provided to date has included: C5-7 interlaminar cervical epidural steroid injection (CESI) on 12/12/2014, cervical fusion, acupuncture use of a brace and a cane, and medications. Diagnostic tests performed include: MRI of the lumbar spine (08/16/2011) showing grade I retrolisthesis at L5-S1 with associated discogenic disease, mild to moderate left L5-S1 neural foraminal stenosis due to disc height loss and the retrolisthesis, and moderate right and mild left L4-5 facet osteoarthritis, computed tomography (CT) scan of the cervical spine (06/06/2011) showing solid C5-6 and C6-7 vertebral body fusion, cervical spondylosis at C2-5, and disc protrusions at C2-3 and C4-5. There were no noted comorbidities. On 02/16/2015, physician progress report noted complaints of neck pain with radiating pain down into both upper extremities, and low back pain radiating into both lower extremities. Pain is rated as 4-5 (0-10) on average with and without medications since the previous exam, and described as unchanged. Additional complaints include insomnia and anxiety. The injured worker reported significant (80%) improvement in pain and symptoms after receiving a CESI on 12/12/2014, which resulted in decreased medication requirements, improved mobility, and improved sleep, with duration of improvement of 6 weeks. The injured worker also reported 95% improvement with use of medications (percocet, antidepressant, anti-seizure medication, muscle relaxant, and non-steroidal anti-inflammatory agent) which allows him to brush teeth, dress, care for pet, drive, home exercise,

sitting, sleeping, standing, travel, vacuuming and walking. The physical exam revealed tenderness to palpation of the cervical vertebrae at C5-7 and myofascial trigger points with twitch response in the right trapezius muscle, mild to moderate restricted range of motion in the cervical spine, significantly increased pain with cervical flexion, decreased sensation in the bilateral upper extremities in C6-7 dermatome, spasms in the lumbar paraspinous musculature, tenderness to palpation in the bilateral paravertebral L3-S1 levels, decreased sensitivity to touch along the dermatome in the bilateral lower extremities, decreased motor strength of the extensor muscles along the L4-S1 dermatome in the bilateral lower extremities, and positive straight leg raise bilaterally. Clorazepate was noted to have been tried and failed in the past. It was noted that the injured worker was currently not working. A pain contract was noted to be on file. Plan of care includes: continued medications (Percocet, clorazepate for anxiety and insomnia, cyclobenzaprine, naloxone, Neurontin and naproxen), CESI to bilateral C5-7, Evzio (emergency kit), and follow-up. On 3/16/15, Utilization Review (UR) non-certified or modified requests for the items currently under Independent Medical Review, citing the MTUS.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325mg Qty: 150.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines On-going management for Opioids Page(s): 78, 92.

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

Decision rationale: This injured worker has chronic neck and back pain. There is insufficient 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. No functional goals were discussed. It was noted that the injured worker was currently not working. No random drug testing was discussed or submitted. An opioid contract was noted to be on file. 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. Pain levels were reported as unchanged. Although medications as a group were noted to result in improvement in activities of daily living, there was no documentation of specific reduction in medication use, reduction in frequency of office visits or treatments, or improvement in work status. 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.

Activities of daily living, adverse effects and medication compliance were discussed. 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, percocet does not meet the criteria for long term opioids as elaborated in the MTUS and is therefore not medically necessary.

Clorazepate 7.5mg Qty: 30.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 23, 66.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines benzodiazepines Page(s): 24. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter: benzodiazepines, insomnia treatment.

Decision rationale: This injured worker was noted to have anxiety and insomnia, for which chlorazepate was prescribed. Per the MTUS, benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. The MTUS states that a more appropriate treatment for anxiety disorder is an antidepressant. The MTUS does not recommend benzodiazepines for long-term use for any condition. The number requested is consistent with long-term use, not a short course of treatment, and the documentation from the physician indicates that this request is a renewal of a previous prescription. The Official Disability Guidelines recommend against prescribing benzodiazepines with opioids and other sedatives. In this case, the treating physician has also prescribed percocet, an opioid. The documentation from the physician states that clorazepate was tried and failed in the past. No physician reports describe the specific criteria for a sleep disorder. Treatment of a sleep disorder, including prescribing hypnotics, should not be initiated without a careful diagnosis. There is no evidence of that in this case. For the treatment of insomnia, pharmacologic agents should only be used after careful evaluation of potential causes of sleep disturbance.

Specific components of insomnia should be addressed. There was no documentation of evaluation of sleep disturbance in the injured worker, and components insomnia were not addressed. Due to length of use in excess of the guideline recommendations, documentation that this medication was failed in the past and lack of documentation of evaluation for sleep disturbance, the request for clorazepate is not medically necessary.

Cervical epidural steroid injection bilateral C5-6 w/ Fluoroscopy: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines epidural steroid injections Page(s): 46.

Decision rationale: The MTUS, chronic pain section, page 46 describes the criteria for epidural steroid injections. Epidural injections are a possible option when there is radicular pain caused by a radiculopathy documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. There must be documentation of failure of conservative treatment such as exercises, physical methods, non-steroidal anti-inflammatory agents, and muscle relaxants. An epidural steroid injection must be at a specific side and level. No more than two nerve root levels should be injected using transforaminal blocks. No more than one interlaminar level should be injected at one session. The MTUS recommends that any repeat injection be considered based on the degree of pain relief and functional improvement 6-8 weeks after the initial injection. In this case, the injured worker was noted to have had a prior

cervical epidural steroid injection at C 5-7 which did result in pain relief and functional improvement. However, the current documentation does not describe sufficient clinical findings of radiculopathy. There were no examination findings showing sensory or motor deficits corresponding with a specific lesion identified by imaging studies. No electrodiagnostic testing reports were submitted. Due to insufficient clinical findings of radiculopathy, the request for cervical epidural steroid injection bilateral C5-6 w/ Fluoroscopy is not medically necessary.

Cervical epidural steroid injection C6-7 w/ Fluoroscopy: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines epidural steroid injections.

Decision rationale: The MTUS, chronic pain section, page 46 describes the criteria for epidural steroid injections. Epidural injections are a possible option when there is radicular pain caused by a radiculopathy documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. There must be documentation of failure of conservative treatment such as exercises, physical methods, non-steroidal anti-inflammatory agents, and muscle relaxants. An epidural steroid injection must be at a specific side and level. No more than two nerve root levels should be injected using transforaminal blocks. No more than one interlaminar level should be injected at one session. The MTUS recommends that any repeat injection be considered based on the degree of pain relief and functional improvement 6-8 weeks after the initial injection. In this case, the injured worker was noted to have had a prior cervical epidural steroid injection at C 5-7 which did result in pain relief and functional improvement.

However, the current documentation does not describe sufficient clinical findings of radiculopathy. There were no examination findings showing sensory or motor deficits corresponding with a specific lesion identified by imaging studies. No electrodiagnostic testing reports were submitted. Due to insufficient clinical findings of radiculopathy, the request for cervical epidural steroid injection C6-7 w/ Fluoroscopy is not medically necessary.

Cyclobenzaprine 10mg Qty: 30.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxant Page(s): 63.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines cyclobenzaprine, muscle relaxants Page(s): 41-42, 63-66.

Decision rationale: This injured worker has chronic back and neck pain. 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. Pain levels were reported as unchanged. Although medications as a group were noted to result in improvement in activities of daily living, there was no

documentation of specific reduction in medication use, reduction in frequency of office visits or treatments, or improvement in work status. Per the MTUS chronic pain medical treatment guidelines, cyclobenzaprine (Flexeril, Fexmid, Amrix, Trabadol) is a skeletal muscle relaxant and a central nervous system depressant. It is recommended as an option for a short course of therapy, with greatest effect in the first four days of treatment. Guidelines state that treatment should be brief. Cyclobenzaprine is not recommended to be used for longer than 2-3 weeks. The addition of cyclobenzaprine to other agents is not recommended. In this case, multiple additional medications were prescribed. Limited, mixed evidence does not allow for a recommendation for chronic use. Due to length of use in excess of the guideline recommendations, and lack of functional improvement, the request for cyclobenzaprine is not medically necessary.

Evzio (emergency kit): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids, partial agonists-antagonists Page(s): 75. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter: naloxone, evzio.

Decision rationale: Evzio is an FDA-approved naloxone drug-device combination indicated for the emergency treatment of opioid overdose. The device is designed to guide an untrained lay user through the process of use for overdose reversal. The MTUS states that naloxone is an opioid antagonist, which is used most often to reverse the effects of agonists and agonist-antagonist-derived opioids. Naloxone is recommended in hospital-based and emergency department settings to address opioid overdose cases. It is recommended on a case-by-case basis for outpatient pre hospital use for patients who are prescribed opioids. The Official Disability Guidelines citation above addresses this kind of naloxone prescription, and has a long and detailed list of criteria for prescription. These criteria include documentation of a complete history that includes questions about prior drug and alcohol use, including previous overdose, recent detoxification or abstinence from drugs, results of a screening tool for potential prescription drug abuse, a complete list of chronic medical illnesses, and a complete medication list. Extensive additional criteria are listed for consideration for use of naloxone, and include active abusers of scheduled drugs, history of substance abuse, patients on methadone or buprenorphine maintenance, patients on high dose of opioids, and other criteria as per the guidelines. A generic formulation is recommended; branded products such as Evzio are only recommended if generic is not available. This injured worker did not meet the criteria as discussed in the ODG for consideration of prescription of naloxone. Detailed history of prior drug and alcohol use and results of a screening tool for potential prescription drug abuse were not documented. There was no history of substance abuse, use of high dose opioids, or location remote from access to emergency care. In addition, the associated opioid (percocet) has been determined to be not medically necessary. As such, the request for Evzio is not medically necessary.

Naloxone 0.4mg/0.4ml syringe: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids, partial agonists-antagonists Page(s): 75. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter: naloxone.

Decision rationale: The MTUS states that naloxone is an opioid antagonist which is used most often to reverse the effects of agonists and agonist-antagonist-derived opioids. Naloxone is recommended in hospital-based and emergency department settings to address opioid overdose cases. It is recommended on a case-by-case basis for outpatient pre-hospital use for patients who are prescribed opioids. The Official Disability Guidelines citation above addresses this kind of naloxone prescription, and has a long and detailed list of criteria for prescription. These criteria include documentation of a complete history that includes questions about prior drug and alcohol use, including previous overdose, recent detoxification or abstinence from drugs, results of a screening tool for potential prescription drug abuse, a complete list of chronic medical illnesses, and a complete medication list. Extensive additional criteria are listed for consideration for use of naloxone, and include active abusers of scheduled drugs, history of substance abuse, patients on methadone or buprenorphine maintenance, patients on high dose of opioids, and other criteria as per the guidelines. This injured worker did not meet the criteria as discussed in the ODG for consideration of prescription of naloxone. Detailed history of prior drug and alcohol use and results of a screening tool for potential prescription drug abuse were not documented. There was no history of substance abuse, use of high dose opioids, or location remote from access to emergency care. In addition, the associated opioid (percocet) has been determined to be not medically necessary. As such, the request for Naloxone 0.4mg/0.4ml syringe is not medically necessary.