

Case Number:	CM14-0162050		
Date Assigned:	10/07/2014	Date of Injury:	01/08/2003
Decision Date:	11/07/2014	UR Denial Date:	09/30/2014
Priority:	Standard	Application Received:	10/02/2014

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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Interventional Spine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 54 years old female with an injury date on 01/08/2003. Based on the 09/09/2014 progress report provided by [REDACTED], the diagnoses are:1. Chronic cervicalgia2. Chronic cephalgia3. Left upper extremity radiculopathy4. Chronic lumbalgia5. Discogenic low back pain, L4-56. Right lower extremity radiculopathy.7. Status post lumbar fusion, L4-58. Status post hardware removal, 12/19/2013. According to this report, the patient complains of severe pain in the low back, right lower extremity, bilateral forearms and hands. The patient also complains of headaches that radiates into the bilateral shoulder and upper thoracic spine along with panic attacks. The patient reports that her "medications are continuing to work effectively, and reduces her pain levels from a 10/10 to a 6-8/10 in intensity." The subjective and objective findings were not included in this report for review. The patient had trigger point injection to the right lumbar paraspinal muscles on 08/22/2014 with "immediate improvement." MRI of the lumbar spine on 04/24/2014 indicates a 2mm disc bulge without central central or lateral spinal stenosis at L1-L2 and L5-S1; and a 2-3 mm disc bulge without central central or lateral spinal stenosis at L3-L4. There were no other significant findings noted on this report. The utilization review denied the request on 09/30/2014. [REDACTED] is the requesting provider, and he provided treatment reports from 02/25/2014 to 09/10/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Neurontin 600mg #90 with 5 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin) Page(s): 18.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin) Page(s): 49, 60. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter Low Back - Lumbar & Thoracic (Acute & Chronic)

Decision rationale: According to the 09/09/2014 report by [REDACTED] this patient presents with severe pain in the low back, right lower extremity, bilateral forearms/hands, headaches that radiates into the bilateral shoulder and upper thoracic spine along with panic attacks. The treater is requesting Neurontin 600mg #90 with 5 refills. Neurontin was first mentioned in the 02/25/14 report; it is unknown exactly when the patient initially started taking this medication. Regarding Anti-epileptic (AKA anti-convulsants) drugs for pain, MTUS Guidelines recommend for "treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain." Review of reports indicate that the patient has neuropathic pain. The ODG guidelines support the use of anti-convulsants for neuropathic pain. However, the treater does not mention that this medication is working. There is no discussion regarding the efficacy of the medication. MTUS page 60 require that medication efficacy in terms of pain reduction and functional gains must be discussed when used for chronic pain. The request is not medically necessary.

Fentanyl 12mcg #10: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 78, 86.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic, Medications for chronic pain; CRITERIA FOR USE OF OPIOIDS Page(s): 44, 60, 61, 76-.

Decision rationale: According to the 09/09/2014 report by [REDACTED] this patient presents with severe pain in the low back, right lower extremity, bilateral forearms/hands, headaches that radiates into the bilateral shoulder and upper thoracic spine along with panic attacks. The treater is requesting Fentanyl 12 mg #10. The MTUS Guidelines page 44 states Duragesic (fentanyl transdermal system) is not recommended as a first line therapy. Duragesic is a trade name of fentanyl transdermal therapeutic system which releases fentanyl, a potent opioid, slowly to the skin. For chronic opiate use, MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and aberrant behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. Percocet was first mentioned in the 02/25/2015 report; it is unknown exactly when the patient initially started taking this medication. Review of reports show numerical scale to assessing the patient's pain levels with and without medication. However, there are no discussions regarding functional improvement

specific to the opiate use. None of the reports discuss significant change in ADLs, change in work status, or return to work attributed to use of Percocet. There is no opiate monitoring such as urine toxicology. MTUS require not only analgesia but documentation of ADL's and functional changes. Given the lack of sufficient documentation demonstrating efficacy from chronic opiate use, the request is not medically necessary.

Fentanyl 75 mcg #10: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic, Medications for chronic pain; CRITERIA FOR USE OF OPIOIDS Page(s): 44, 60, 61, 76-.

Decision rationale: According to the 09/09/2014 report by [REDACTED] this patient presents with severe pain in the low back, right lower extremity, bilateral forearms/hands, headaches that radiates into the bilateral shoulder and upper thoracic spine along with panic attacks. The treater is requesting Fentanyl 75mg #10. The MTUS Guidelines page 44 states Duragesic (fentanyl transdermal system) is not recommended as a first line therapy. Duragesic is a trade name of fentanyl transdermal therapeutic system which releases fentanyl, a potent opioid, slowly to the skin. For chronic opiate use, MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and aberrant behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. Percocet was first mentioned in the 02/25/2015 report; it is unknown exactly when the patient initially started taking this medication. Review of reports show numerical scale to assessing the patient's pain levels with and without medication. However, there are no discussions regarding functional improvement specific to the opiate use. None of the reports discuss significant change in ADLs, change in work status, or return to work attributed to use of Percocet. There is no opiate monitoring such as urine toxicology. MTUS require not only analgesia but documentation of ADL's and functional changes. Given the lack of sufficient documentation demonstrating efficacy from chronic opiate use, the request is not medically necessary.

Percocet 10/325mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78, 86.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 60, 61, 76-78, 88, 89.

Decision rationale: According to the 09/09/2014 report by [REDACTED] this patient presents with severe pain in the low back, right lower extremity, bilateral forearms/hands, headaches that

radiates into the bilateral shoulder and upper thoracic spine along with panic attacks. The treater is requesting Percocet 10/325 mg #90. For chronic opiate use, MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and aberrant behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. Percocet was first mentioned in the 02/25/2015 report; it is unknown exactly when the patient initially started taking this medication. Review of reports show numerical scale to assessing the patient's pain levels with and without medication. However, there are no discussions regarding functional improvement specific to the opiate use. None of the reports discuss significant change in ADLs, change in work status, or return to work attributed to use of Percocet. There is no opiate monitoring such as urine toxicology. MTUS require not only analgesia but documentation of ADL's and functional changes. Given the lack of sufficient documentation demonstrating efficacy from chronic opiate use, the request is not medically necessary.

Tegaderm Dressing 6x8 #15: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tegaderm Page(s): 8.

Decision rationale: According to the 09/09/2014 report by [REDACTED] this patient presents with severe pain in the low back, right lower extremity, bilateral forearms/hands, headaches that radiates into the bilateral shoulder and upper thoracic spine along with panic attacks. The treater is requesting Tegaderm dressing 6 x 8 #15 to use over the fentanyl patch. Given that Fentanyl patches is not indicated for this patient's condition, there would not no need for tegaderm. The request is not medically necessary.

Medial Branch Block Bilateral L3-L4-L5: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Facet joint diagnostic blocks (injections)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG low back chapter under Facet joint diagnostic blocks (injections) and Facet joint medial branch blocks (therapeutic injections)

Decision rationale: According to the 09/09/2014 report by [REDACTED] this patient presents with severe pain in the low back, right lower extremity, bilateral forearms/hands, headaches that radiates into the bilateral shoulder and upper thoracic spine along with panic attacks. The treater

is requesting repeat medial branch block at the L3-L4-L5, bilaterally. The utilization review denial letter states "no physical exam examination findings were submitted to show evidence of facet mediated pain." Regarding medial branch blocks, MTUS does not address it, but ODG low back chapter recommends it for "low-back pain that is non-radicular and at no more than two levels bilaterally." The 07/28/2014 report reveals "severe tenderness in the low back region. Extension increases her guarding." The 07/15/2014 report indicates the patient is status post diagnostic facet block at L3-L4 and L4-5 on 06/23/2014 with "70% improvement overall." The patient has non-radiating (non-dermatomal distribution) low back pain with paraspinal muscles tenderness upon palpation. Evaluation of the facet joints would appear to be reasonable and consistent with ODG Guidelines. However, the treater is requesting a repeat MBB at L3-L4-L5 bilaterally. ODG recommend medial branch block as a "diagnostic tool" and "recommend no more than one set of medial branch diagnostic blocks." The requested repeat MBB is not supported by the guidelines. The request is not medically necessary.