

Case Number:	CM15-0100391		
Date Assigned:	06/02/2015	Date of Injury:	05/12/1994
Decision Date:	06/30/2015	UR Denial Date:	05/06/2015
Priority:	Standard	Application Received:	05/26/2015

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 67 year old male who sustained an industrial injury on 05/12/1994. Mechanism of injury occurred during the course of his usual work duties. Diagnoses include lumbar disc degeneration, chronic pain, lumbar facet arthropathy, lumbar post laminectomy syndrome, lumbar radiculitis, status post lumbar fusion, depression insomnia; mediation related dyspepsia and status post spinal cord stimulator implant. Treatment to date has included diagnostic studies, medications, status post spinal cord stimulator, and facet medial nerve radiofrequency rhizotomy with good (50-80%) improvement, occipital nerve blocks, and physical therapy. A cervical spine computed tomography done on 07/25/2014 revealed minimal central canal stenosis and mild to moderate left neural foraminal stenosis is seen at C6-7 secondary to a 3mm left paracentral discogenic osteophyte disc bulge complex/disc protrusion. There is mild straightening of the normal lordotic curvature which may be related to patient positioning and/or muscular spasm. X-rays of the lumbar spine done on 03/17/2014 shows status post posterior fusion and neural stimulator lead placement. L1-2 shows posterior disc bulge resulting in moderate right and moderate to severe left neural foraminal narrowing and mild canal stenosis is seen. L2-3 shows a 3-4 mm posterior disc bulge resulting in mild to moderate right and moderate to severe left neural foraminal narrowing and mild canal stenosis. L3-4 shows a 3-4 mm posterior disc bulge efface the ventral surface of the thecal sac resulting in moderate to severe bilateral neural foraminal narrowing, and moderate canal stenosis is seen. L4-5 shows a 1-2mm posterior disc bulge resulting in moderate bilateral neural foraminal narrowing in conjunction with facet joint hypertrophy and moderate canal stenosis is seen. L5-

S1 shows status post fusion and artificial disc space replacing with residual osteophytic ridge and facet joint hypertrophy resulting in moderate to severe right and moderated left neural foraminal narrowing. A physician progress note dated 04/15/2015 documents the injured worker complains of neck pain, low back pain which is constant and does not radiate to the lower extremities. He does have intermittent radiation of pain to his right foot. He describes the pain as stabbing. He has moderate difficulty sleeping. He has complaints of occipital headaches. Pain is rated as 7 out of 10 on average with medications, and without medications pain is 10 out of 10. The pain is worsening since his last visit. Examination of the cervical spine reveals tenderness upon palpation bilaterally. Range of motion is moderate to severely limited due to pain. Examination of the lumbar spine reveals tenderness to palpation and range of motion was moderately limited secondary to pain. Straight leg raise at 90 degrees in the sitting position is negative bilaterally. The treatment plan is for Gabapentin, Vitamin D, Trazodone and Naproxen. Treatment requested is for Bilateral L4-S1 Facet Medial Branch Nerve Blocks via Fluoroscopic Guidance, Butrans 5mcg #4, and a Urine Drug Test.

IMR ISSUES, DECISIONS AND RATIONALES

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

Urine Drug Test: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic), Urine Drug Testing (UDT).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, steps to avoid misuse/addiction Page(s): (s) 77-78; 94.

Decision rationale: According to MTUS guidelines, urine toxicology screening is indicated to avoid misuse/addiction. "(j) Consider the use of a urine drug screen to assess for the use or the presence of illegal drugs." In this case, there is no documentation of drug abuse or aberrant behavior. There is no documentation of drug abuse or misuse. There is no rationale provided for requesting UDS test. Therefore, Urine Drug screen is not medically necessary.

Bilateral L4-S1 Facet Medial Branch Nerve Blocks via Fluoroscopic Guidance: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-301, 309. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back - Lumbar & Thoracic (Acute & Chronic): Facet joint intra-articular injections (therapeutic blocks).

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. The ODG guidelines did not support facet injection for lumbar pain in this clinical context. There is no documentation of facet mediated pain or that facets are the main pain generator. There is no documentation of failure of conservative therapies in this patient. Therefore, the request for Bilateral L4-S1 Facet Medial Branch Nerve Blocks via Fluoroscopic Guidance is not medically necessary.

Butrans 5mcg #4: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Buprenorphine. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic), Buprenorphine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of opioids Page(s): 76-79.

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." According to

MTUS guidelines, Butrans is recommended to treat opiate addiction. There is no clear documentation of patient improvement in level of function, quality of life, adequate follow up or absence of side effects and aberrant behavior with previous use of opioids. The patient continued to have significant pain with Butrans. There is no recent documentation of recent opioid addiction. Therefore, the request for Butrans 5mcg #4 is not medically necessary.