

<b>Case Number:</b>	CM15-0161262		
<b>Date Assigned:</b>	09/24/2015	<b>Date of Injury:</b>	02/14/2010
<b>Decision Date:</b>	11/18/2015	<b>UR Denial Date:</b>	08/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/18/2015

### 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: California

Certification(s)/Specialty: Emergency 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 62 year old male, who sustained an industrial injury on February 14, 2010. The injured worker was diagnosed as having degenerative cervical intervertebral disc disease, sacroiliitis not elsewhere classified, post lumbar laminectomy syndrome, lumbosacral spondylosis without myelopathy, lumbar and lumbosacral intervertebral degenerative disc disease, lumbago, and spasm of the muscle. Treatment and diagnostic studies to date has included computed tomography of the lumbar spine post myelogram, status post second fusion at the lumbar four to five and lumbar five to sacral one, medication regimen, spinal cord stimulator trial, magnetic resonance imaging of the lumbar spine, physical therapy, transforaminal epidural steroid injection of the lumbar spine, magnetic resonance imaging of the cervical spine, and electromyogram with nerve conduction study to the bilateral lower extremities. In a progress note dated July 20, 2015 the pain management physician reports complaints of an increase in pain to the neck and low back. Examination performed on July 20, 2015 was revealing for complaints of residual axial low back pain that was noted to be greater than leg pain that increases with sitting, complaints of "severe" neck pain with pain to the bilateral arms and hands with the right greater than the left, and complaints of headache. On July 20, 2015 the injured worker's medication regimen included Cymbalta (since at least December 2014), Neurontin (since at least December 2014), Norco (since at least August 2010), and Nucynta ER (since at least December 2014). On July 20, 2015 the injured worker's pain level was rated an 8 to 9 out of 10 and his functional level was rated a 4 out of 10, but the progress note did not indicate the injured worker's pain level and functional level prior to use of his medication regimen and after

use of his medication regimen to indicate the effects of the injured worker's medication regimen. On July 20, 2015 the pain management physician noted a computed tomography lumbar myelogram performed on January 17, 2014 that was revealing for multilevel degenerative changes to the lumbar spine, central disc osteophyte complex indenting the anterior thecal sacroiliac at thoracic twelve and lumbar one, retrolisthesis with uncovering a diffuse disc bulge to the left paracentral and left foraminal component indenting the anterior thecal sacroiliac along with posterior epidural fat leading to spinal canal stenosis and left lateral recess stenosis at lumbar two to three, diffuse posterior disc osteophyte complex with bilateral foraminal component leading to bilateral neural foraminal stenosis encroaching on the right lumbar five nerve root, levoscoliosis, and degenerative disc disease to the anterior sacroiliac joints. Examination performed by the treating physician on June 25, 2015 was revealing for pain to the lumbar paraspinal muscles, weakness to the right leg with the right leg giving out, dysesthesia to the bilateral legs with the right greater than the left, and a pain rating of a 9 out of 10 to the low back. Supplemental Agreed Medical Evaluation performed on September 02, 2011 included magnetic resonance imaging of the cervical spine performed on July 19, 2011 to be revealing for cervical five to six disc and osteophyte complex to the lateral recesses and the neural foramina bilaterally with the left greater than the right and a bulging disc at cervical six to seven. On July 20, 2015 the pain management physician requested Nucynta ER 250mg with a quantity of 60 with 1 refill as needed for baseline pain, Norco 10-325mg with a quantity of 150 with 1 refill noting current use of this medication, and an unknown prescription of Flexeril with 1 refill as prescribed by the injured worker's primary treating physician with the progress note indicating current use of these medications as noted above. The pain management physician also requested a bilateral lumbar one, two, and three medial branch blocks noting back pain above the fusion and a right cervical five to six selective cervical epidural steroid injection, but the progress note did not indicate the specific reason for the requested epidural injection. On August 04, 2015 the Utilization Review determined the requests for Nucynta ER 250mg with a quantity of 60 with 1 refill, Norco 10-325mg with a quantity of 150 with 1 refill, an unknown prescription of Flexeril with 1 refill, a bilateral lumbar one, two, and three medial branch block, and a right cervical five to six selective cervical epidural steroid injection to be non-certified.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Nucynta ER 250 MG #60 with 1 Refill: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

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

**Decision rationale:** The request is for the use of a medication in the opioid class. The MTUS guidelines state that for ongoing treatment with a pharmaceutical in this class, certain requirements are necessary. This includes not only adequate pain control, but also functional improvement. Four domains have been proposed for management of patients on opioids. This includes pain relief, side effects, physical and psychosocial functioning, and the occurrence of

any potentially aberrant drug-related behaviors. In this case, there is inadequate documentation of persistent functional improvement seen. Also, the MED far exceeds the recommendations. As such, the request is not certified. All opioid medications should be titrated down slowly in order to prevent a significant withdrawal syndrome.

**Norco 10/325 MG #150 with 1 Refill:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

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

**Decision rationale:** The request is for the use of a medication in the opioid class. The MTUS guidelines state that for ongoing treatment with a pharmaceutical in this class, certain requirements are necessary. This includes not only adequate pain control, but also functional improvement. Four domains have been proposed for management of patients on opioids. This includes pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant drug-related behaviors. In this case, there is inadequate documentation of persistent functional improvement seen. Also, the MED far exceeds the recommendations. As such, the request is not certified. All opioid medications should be titrated down slowly in order to prevent a significant withdrawal syndrome.

**Unknown Prescription of Flexeril with 1 Refill:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

**Decision rationale:** The request is for the use of a muscle relaxant to aid in pain relief. The MTUS guidelines state that the use of a medication in this class is indicated as a second-line option for short-term treatment of acute exacerbations of low back pain. Muscle relaxants may be effective in reducing pain and muscle tension, which can increase mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain improvement. Efficacy appears to diminish over time, and prolonged use may lead to dependence. (Homik, 2004) Due to inadequate documentation of a recent acute exacerbation and poor effectiveness for chronic long-term use, the request is not certified.

**Bilateral L123 MBB:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

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

**Decision rationale:** The request is for a medial branch block to aid in pain relief. The ODG guidelines state the following regarding this topic: Not recommended except as a diagnostic tool. Minimal evidence for treatment. Pain Physician 2005: In 2005 Pain Physician published an article that stated that there was moderate evidence for the use of lumbar medial branch blocks for the treatment of chronic lumbar spinal pain. (Boswell, 2005) This was supported by one study. (Manchikanti, 2001) Patients received either a local anesthetic or a local anesthetic with methyl prednisolone. All blocks included Sarapin. Sixty percent of the patients overall underwent seven or more procedures over the 2 year study period (8.4 0.31 over 13 to 32 months). There were more procedures recorded for the group that received corticosteroids than those that did not (301 vs. 210, respectively). ["Moderate evidence" is a definition of the quality of evidence to support a treatment outcome according to Pain Physician.] The average relief per procedure was 11.9 3.7 weeks. Pain Physician 2007: This review included an additional randomized controlled trial. (Manchikanti2, 2007) Controlled blocks with local anesthetic were used for the diagnosis (80% reduction of pain required). Four study groups were assigned with 15 patients in each group: (1) bupivacaine only; (2) bupivacaine plus Sarapin; (3) bupivacaine plus steroid; and (4) bupivacaine, steroid and Sarapin. There was no placebo group. Doses of 1-2ml were utilized. The average number of treatments was 3.7 and there was no significant difference in number of procedures noted between the steroid and non-steroid group. Long-term improvement was only thought to be possible with repeat interventions. All groups were significantly improved from baseline (a final Numeric Rating Scale score in a range from 3.5 to 3.9 for each group). Significant improvement occurred in the Oswestry score from baseline in all groups, but there was also no significant difference between the groups. There was no significant difference in opioid intake or employment status. There was no explanation posited of why there was no difference in results between the steroid and non-steroid groups. This study was considered positive for both short and long-term relief, although, as noted, repeated injections were required for a long-term effect. Based on the inclusion of this study the overall conclusion was changed to suggest that the evidence for therapeutic medial branch blocks was moderate for both short and long-term pain relief. (Boswell2, 2007) Psychiatric comorbidity is associated with substantially diminished pain relief after a medial branch block injection performed with steroid at one-month follow-up. These findings illustrate the importance of assessing comorbid psychopathology as part of a spine care evaluation. (Wasan, 2009) The use of the blocks for diagnostic purposes is discussed in Facet joint diagnostic blocks (injections). The AHRQ comparative effectiveness study on injection therapies for LBP concluded that facet joint corticosteroid injections are not effective for presumed facet joint pain. (Chou, 2015) See also Facet joint intra-articular injections (therapeutic blocks). In this case, the procedure is not supported by the guidelines. As stated above, there is poor clinical evidence of efficacy. As such, the request is not certified. In this case, the procedure is not supported by the guidelines. As stated above, there is poor clinical evidence of efficacy. As such, the request is not certified.

**Right C5/6 Selective Cervical ESI:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) neck and upper back (acute & chronic)/Epidural steroid injections (ESIs).

**Decision rationale:** The request is for an epidural steroid injection to aid in cervical pain relief. The official disability guidelines state the following regarding this issue: "Not recommended based on recent evidence, given the serious risks of this procedure in the cervical region, and the lack of quality evidence for sustained benefit. These had been recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy), with specific criteria for use below." In this case, an epidural steroid injection is not indicated. This is secondary to poor clinical evidence regarding sustained benefit. As such, the request is not certified.