

Case Number:	CM15-0176241		
Date Assigned:	09/17/2015	Date of Injury:	02/19/2009
Decision Date:	11/06/2015	UR Denial Date:	08/13/2015
Priority:	Standard	Application Received:	09/09/2015

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 39 year old male, who sustained an industrial injury on 2-19-2009. The medical records indicate that the injured worker is undergoing treatment for failed back surgery syndrome, facet arthropathy, and lumbar myofascitis. According to the progress report dated 7-20-2015, the injured worker complains of constant low back pain, especially in the left side, worst with bending backwards, sitting, standing, or twisting. The pain is rated 7 out of 10 on a subjective pain scale. The physical examination of the lumbar spine reveals pain to palpation over the L3, L4, and L5. Range of motion is limited to 45 degrees with forward flexion, 10 degrees with extension, and 20 degrees with left lateral flexion, 30 degrees right lateral rotation, and 25 degrees with left lateral rotation. The current medications are Hydrocodone, Prilosec, and Lidoderm patches. There is documentation of ongoing treatment with Norco and Prilosec since at least 1-19-2015, and Lidoderm patches since at least 6-8-2015. Treatment to date has included medication management, physical therapy, electrodiagnostic testing, and surgical intervention. On the 6-24-2015 progress note, work status is described as no lifting, pushing, or pulling over 5 pounds. The original utilization review (8-13-2015) had non-certified a request for (unknown) Norco, (unknown) Prilosec, (unknown) Lidoderm patch, and left branch medial nerve block at L3-L4, L4-L5 and L5-S1.

IMR ISSUES, DECISIONS AND RATIONALES

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

One left branch medial nerve block at L3-L4, L4-L5 and L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back (Lumbar & Thoracic) (Acute & Chronic): Facet joint diagnostic blocks (injections) (2015).

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 either received 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 medically necessary.

Unknown Norco: 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. As such, the request is not medically necessary. All opioid medications should be titrated down slowly in order to prevent a significant withdrawal syndrome.

Unknown Prilosec: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation ODG, Pain (Chronic): Proton pump inhibitors (PPIs) (2015).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

Decision rationale: The request is for the use of a medication in the class of a proton pump inhibitor. It is indicated for patients with peptic ulcer disease. It can also be used as a preventative measure in patients taking non-steroidal anti-inflammatories for chronic pain. Unfortunately, they do have certain side effects including gastrointestinal disease. The MTUS guidelines states that patients who are classified as intermediate or high risk, should be treated prophylactically. Criteria for risk are as follows: "(1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA)". Due to the fact the patient does not meet to above stated criteria, the request for use is not medically necessary.

Unknown Lidoderm patch: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation ODG, Pain (Chronic): Lidoderm (lidocaine patch) (2015).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: The request is for the use of a Lidoderm patch to aid in pain relief. The MTUS guidelines state that its use is indicated for post herpetic neuralgia after an initial trial of an anti-epileptic medication. Further research is needed to recommend use for chronic neuropathic disorders besides post-herpetic neuralgia. In this case, the patient does not have a diagnosis documented, which would justify the use of Lidoderm patches. As such, the request is not medically necessary.