

Case Number:	CM15-0177605		
Date Assigned:	09/18/2015	Date of Injury:	05/02/2008
Decision Date:	10/21/2015	UR Denial Date:	08/11/2015
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: North Carolina

Certification(s)/Specialty: Family Practice

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 59 year old male, who sustained an industrial injury on 5-2-2008. The medical records indicate that the injured worker is undergoing treatment for multi-level cervical facet syndrome most prominent on the right C2 through C5, multi-level disc protrusions with C3-C4 through C5-C6 bilateral neuroforaminal narrowing, chronic bilateral rotator cuff tears unresponsive to surgical repair, increasing reactive depression, right ulnar neuropathy, status post right elbow surgery, and history of bilateral knee arthroscopy and left ACL repair. According to the progress report dated 7-30-2015, the injured worker complains of an increase in his neck and head pain. The level of pain is not rated. The physical examination reveals cervical tenderness to palpation over the right C2 through C5 facet joints. There is radiation from these areas into the head. Cervical range of motion is within normal limits, but creates pain into the trapezius and shoulders. Cervical extension is most painful creating head and neck pain. The current medications are Nucynta, Vimovo, Topamax, and Paxil. Per notes, he was advised to increase his Topamax 25mg to 50mg at night to decrease his neuropathic symptoms, headaches, and improve sleep. There is documentation of ongoing treatment with Nucynta since at least 2014 and Topamax since at least 4-16-2015. Treatment to date has included medication management, aqua therapy, TENS unit, MRI studies, epidural steroid injection, and surgical intervention. MRI from 7-9-2015 notes "multi-level cervical facet arthropathy, also multi-level disc protrusions with C4-C5 bilateral neuroforaminal narrowing, C5-C6 neuroforaminal narrowing and C6-C7 neuroforaminal narrowing". Work status is described as not working. The original utilization review (8-11-2015) partially approved a request for Nucynta # 15 (original request was for #30). The request for Topamax #60 and right cervical facet injection was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 prescription of Nucynta ER 50mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) (2015).

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

Decision rationale: The California chronic pain medical treatment guidelines section on opioids states for ongoing management: On-Going Management. Actions Should Include: (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 for documentation of the clinical use of these controlled drugs. (Passik, 2000) (d) Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain diary that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management. (e) Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control. (f) Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion). (g) Continuing review of overall situation with regard to non-opioid means of pain control. (h) Consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consult if there is evidence of substance misuse. When to Continue Opioids: (a) If the patient has returned to work; (b) If the patient has improved functioning and pain (Washington, 2002) (Colorado, 2002) (Ontario, 2000) (VA/DoD, 2003) (Maddox-AAPM/APS, 1997) (Wisconsin, 2004) (Warfield, 2004) The long-term use of this medication class is not recommended per the California MTUS unless there documented evidence of benefit with measurable outcome measures and improvement in function. There is no documented significant improvement in VAS scores for significant periods of time. There are no objective measurements of improvement in function or activity specifically due to the medication. Therefore all criteria for the ongoing use of opioids have not been met and the request is not medically necessary.

1 prescription of Topamax 25mg #60: 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): Antiepilepsy drugs (AEDs).

Decision rationale: The California MTUS section on Topamax states: Topiramate (Topamax, no generic available) has been shown to have variable efficacy, with failure to demonstrate efficacy in neuropathic pain of "central" etiology. It is still considered for use for neuropathic pain when other anticonvulsants fail. Topiramate has recently been investigated as an adjunct treatment for obesity, but the side effect profile limits its use in this regard. (Rosenstock, 2007) The patient does have neuropathic pain but no documentation of failure of first line anticonvulsant therapy. Therefore, the request is not medically necessary.

1 right cervical facet injection: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper back (Acute & Chronic) (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 injections.

Decision rationale: The ACOEM states: 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. Per the ODG, facet joint injections are under study. Current evidence is conflicting as to this procedure and at this time no more than one therapeutic intra-articular block is suggested. Intra-articular facet joint injections have been popularly utilized as a therapeutic procedure, but are currently not recommended as a treatment modality in most evidence based reviews as their benefit remains controversial. Criteria for use of diagnostic blocks for facet nerve pain: 1. One set of diagnostic medial branch blocks is required with a response of 70%, 2. Limited to non-radicular cervical pain and no more than 2 levels bilaterally. 3. Documentation of failure of conservative therapy, 4. No more than 2 joint levels are injected in 1 session, 5. Diagnostic facet blocks should be performed in patients whom a surgical procedure is anticipated. The requested service is not recommended per the ACOEM or the Official Disability Guidelines. Criteria have not been met in the provided clinical documentation as the patient does have radicular pain symptoms and no facet tenderness at selected levels. Therefore, the request is not medically necessary.