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## Independent Medical Review Final Determination Letter

[REDACTED]  
[REDACTED]  
[REDACTED]

Dated: 12/17/2013

Employee: [REDACTED]  
Claim Number: [REDACTED]  
Date of UR Decision: 7/22/2013  
Date of Injury: 11/8/1999  
IMR Application Received: 8/15/2013  
MAXIMUS Case Number: CM13-0011225

DEAR [REDACTED],

MAXIMUS Federal Services has completed the Independent Medical Review (“IMR”) of the above workers’ compensation case. This letter provides you with the IMR Final Determination and explains how the determination was made.

Final Determination: PARTIAL OVERTURN. This means we decided that some (but not all) of the disputed items/services are medically necessary and appropriate. A detailed explanation of the decision for each of the disputed items/services is provided later in this letter.

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties.

In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, MD, MPH  
Medical Director

cc: Department of Industrial Relations, [REDACTED]

## HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Anesthesiology, and Pain Medicine, and is licensed to practice in Florida. 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 physician 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.

### DOCUMENTS REVIEWED

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- Application of Independent Medical Review
- Utilization Review Determination
- Medical Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

### CLINICAL CASE SUMMARY

The physician reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 46-year-old female who reported an injury on 11/08/1999. The patient has a history of low back pain secondary to failed back syndrome. The patient also has a history of DVTs. The patient has been treated with lumbar epidural steroid injection with 50% relief and trigger point injections with greater than 50% relief. The patient has a current medication regimen including Duragesic patch 100 mcg, OxyContin 80 mg every 8 hours, oxycodone 5 mg every 6 hours, Flexeril 10 mg 3 times a day, Effexor 37.5 mg twice a day, Zanaflex 4 mg every 8 hours, Ambien 12.5 mg 1 pill a night, Lorazepam 2 mg every 8 hours, and Lexapro 20 mg once a day. The employee has limited cervical spine range of motion with tenderness, positive bilateral straight leg raise, normal gait, decreased strength in the bilateral lower extremities, decreased sensation in the left L3 to S1 dermatomes to pinprick, decreased sensation in the bilateral lower extremities to light touch, absent bilateral Achilles reflexes, and right foot drop. The employee is known to have a history of consistent urine drug screens. The most recent note indicates that the employee was to be tapered off oxycodone over 3 months and then the provider would work on tapering other medications. The employee has a diagnosis of cervicalgia, post-laminectomy syndrome lumbar region, pain in joint, trochanteric bursitis, and myalgia.

### IMR DECISION(S) AND RATIONALE(S)

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

#### **1. Caudal epidural steroid injection (ESI) under fluoroscopic guidance is medically necessary and appropriate.**

The Claims Administrator based its decision on the CA MTUS/ACOEM.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Epidural steroid injection (ESI), pg. 46, which is part of the MTUS.

The Physician Reviewer's decision rationale:

CA MTUS guidelines state that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. CA MTUS guidelines also state that the patient should be initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). The employee has undergone prior lumbar caudal epidural steroid injections with good benefits. The last injection was noted to be in 05/2012 with 3 to 4 months of relief. A clinical note on 06/04/2012 reported the employee had at least 50% relief. The employee does have current neurological deficits that would warrant the use of a caudal epidural steroid injection. The employee would benefit from a repeat injection given ongoing complaints, neurological deficits, and prior success of greater than 50% to 70% pain relief for 6 to 8 weeks. **The request for caudal epidural steroid injection (ESI) under fluoroscopic guidance is not medically necessary and appropriate.**

## **2. Left shoulder subacromial injection is not medically necessary and appropriate.**

The Claims Administrator based its decision on the CA MTUS/ACOEM.

The Physician Reviewer based his/her decision on the American College of Occupational and Environmental Medicine (ACOEM), 2<sup>nd</sup> Edition, (2004), Shoulder Complaints, pages 201-205, which is part of the MTUS.

The Physician Reviewer's decision rationale:

CA MTUS / ACOEM guidelines states that "a subacromial injection of local anesthetic and a corticosteroid preparation may be indicated after conservative therapy (i.e., strengthening exercises and nonsteroidal anti-inflammatory drugs) for two to three weeks." The documentation submitted for review fails to reveal significant physical exam findings consistent with left shoulder impingement syndrome. There is also a lack of imaging studies with regard to the left shoulder. There is also a lack of documentation of conservative care directed towards the patient's left shoulder. **The request for left shoulder subacromial injection is not medically necessary and appropriate.**

## **3. trigger point injections is not medically necessary and appropriate.**

The Claims Administrator based its decision on the CA MTUS/ACOEM.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, trigger point injections, page 122, which is part of the MTUS.

The Physician Reviewer's decision rationale:

CA MTUS guidelines states that there should be "Documentation of circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain; (2) Symptoms have persisted for more than three months; (3) Medical management therapies such as ongoing stretching exercises, physical therapy, NSAIDs and muscle relaxants have failed to control pain; (4) Radiculopathy is not present (by exam, imaging, or neuro-testing); (5) Not more than 3-4 injections per session; (6) No repeat injections unless a greater than 50% pain relief is obtained for six weeks after an injection and there is documented evidence of functional improvement; (7) Frequency should not be at an interval less than two months; (8) Trigger point injections with any substance (e.g., saline or glucose) other than local anesthetic with or without steroid are not recommended." The documentation submitted for review indicates that the employee has a good success rate with prior trigger point injections. However, California MTUS Guidelines specifically state that radiculopathy should not be present. The employee does have evidence of

lumbar radiculopathy and was authorized for a caudal epidural steroid injection for this diagnosis. Furthermore, the recent physical examinations fail to reveal a circumscribed trigger point with positive twitch response upon palpation. The request for **trigger point injections is not medically necessary and appropriate.**

#### **4. Lorazepam is not medically necessary and appropriate.**

The Claims Administrator based its decision on the CA MTUS/ACOEM.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Benzodiazepines, page 23, which is part of the MTUS.

The Physician Reviewer's decision rationale:

CA MTUS guidelines states that Lorazepam, Benzodiazepines, are "Not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence." The documentation submitted for review indicates the employee has been using Lorazepam for over a year and a half. Guidelines do not recommend the long-term use of Lorazepam. **The request for Lorazepam is not medically necessary and appropriate.**

#### **5. Ambien CR is not medically necessary and appropriate.**

The Claims Administrator based its decision on the CA MTUS/ACOEM.

The Physician Reviewer based his/her decision on the Official Disability Guidelines (ODG) Pain Chapter, which is part of the MTUS.

The Physician Reviewer's decision rationale:

Official Disability Guidelines states that "Zolpidem is a prescription short-acting nonbenzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia." The documentation indicates the patient has been utilizing Ambien for over a year and a half. There is lack of documentation of any significant improvement in the patient's sleep pattern with medication management. Furthermore, the ongoing prescription would exceed evidence-based guidelines and the recommendation for total duration of care to not exceed 6 weeks. **The request for Ambien CR is not medically necessary and appropriate.**

#### **6. Zanaflex is not medically necessary and appropriate.**

The Claims Administrator based its decision on the CA MTUS/ACOEM.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Muscle relaxants (for pain), Tizanidine pages 63-66, which is part of the MTUS.

The Physician Reviewer's decision rationale:

CA MTUS guidelines states that Zanaflex, muscle relaxant, is "Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP." The employee has been utilizing Zanaflex for over a year and a half. Guidelines only recommend use of Zanaflex for short-term treatment of an acute exacerbation. Therefore, ongoing utilization of Zanaflex would exceed evidence-based guidelines for total duration of care. **The request for Zanaflex is not medically necessary and appropriate.**

## **7. Oxycontin is not medically necessary and appropriate.**

The Claims Administrator based its decision on the CA MTUS/ACOEM.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Opioids, pages 76-78, which is part of the MTUS.

The Physician Reviewer's decision rationale:

CA MTUS guidelines states that "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 nonadherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drugtaking 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." The documentation submitted for review does indicate that the employee has had consistent urine drug screens. The clinical note on 08/27/2013 reported that the employee was utilizing Duragesic, OxyContin, and oxycodone. Guidelines do not recommend greater than 120 mg equivalent of morphine per day. The employee's current medication regimen is in excess of 600 mg per day. The documentation fails to demonstrate any significant objective functional improvement or substantial pain relief with current medication regimen to support ongoing use. **The request for Oxycontin is not medically necessary and appropriate.**

## **8. Oxycodone HCL is not medically necessary and appropriate.**

The Claims Administrator based its decision on the CA MTUS/ACOEM.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Opioids, pages 76-78, which is part of the MTUS.

The Physician Reviewer's decision rationale:

CA MTUS guidelines states that "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 nonadherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drugtaking 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." The documentation submitted for review does indicate that the employee has had consistent urine drug screens. The clinical note on 08/27/2013 reported that the employee was utilizing Duragesic, OxyContin, and oxycodone. Guidelines do not recommend greater than 120 mg equivalent of morphine per day. The employee's current medication regimen is in excess of 600 mg per day. The documentation fails to demonstrate any significant objective functional improvement or substantial pain relief with current medication regimen to support ongoing use. **The request for Oxycodone HCL is not medically necessary and appropriate.**

## **9. Duragesic is not medically necessary and appropriate.**

The Claims Administrator based its decision on the CA MTUS/ACOEM.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Duragesic, page 93, which is part of the MTUS.

The Physician Reviewer's decision rationale:

CA MTUS guidelines states that Duragesic "Indicated for management of persistent chronic pain, which is moderate to severe requiring continuous, around-the-clock opioid therapy." The documentation submitted for review does indicate that the employee has had consistent urine drug screens. The clinical note on 08/27/2013 reported that the employee was utilizing Duragesic, OxyContin, and oxycodone. Guidelines do not recommend greater than 120 mg equivalent of morphine per day. The employee's current medication regimen is in excess of 600 mg per day. The documentation fails to demonstrate any significant objective functional improvement or substantial pain relief with current medication regimen to support ongoing use. **The request for Duragesic is not medically necessary and appropriate.**

Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.

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