

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM13-0020209 | | |
| Date Assigned: | 10/11/2013 | Date of Injury: | 11/08/1999 |
| Decision Date: | 01/17/2014 | UR Denial Date: | 08/16/2013 |
| Priority: | Standard | Application Received: | 09/05/2013 |

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, has a subspecialty in 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. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 46-year-old female who reported injury on 11/08/1999 with an unstated mechanism of injury. The patient was noted to have chronic severe low back pain and radiating lower extremity pain. The patient's chief complaint was noted to be neck, low back, and leg pain. The diagnoses were noted include cervicgia, postlaminectomy syndrome lumbar region, pain in joint multiple sites, trochanteric bursitis, unspecified myalgia and myositis, and long term use of medication. The request was made for repeat caudal ESI under fluoroscopic guidance, left shoulder subacromial injection, trigger point injections, new TENS unit, lorazepam, Ambien CR, Zanaflex, OxyContin, oxycodone, and Duragesic.

IMR ISSUES, DECISIONS AND RATIONALES

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

A repeat caudal epidural steroid injections (ESI) under fluoroscopic guidance: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ESIs Page(s): 46.

Decision rationale: California MTUS guidelines recommend, for a repeat ESI, there must be objective documented pain and functional improvement, including at least 50% pain relief with

associated reduction of medication use for 6 weeks to 8 weeks, with a general recommendation of no more than 4 blocks per region per year. The patient was noted to have 70% relief with the prior block. The clinical documentation submitted for review indicated that the patient had limited range of motion in the neck with tenderness over the left cervical facets and a palpable knot in the shoulders. The patient's range of motion was noted to be limited with 45 degrees of motion. The patient was noted to have tenderness to palpation in the paraspinal region. The patient was noted to have tenderness to palpation in the paraspinal lumbar region. The patient was noted to have decreased range of motion. While clinical documentation submitted for review indicated the patient had objective physical findings to support radiculopathy, the level for the ESI was not provided, and the patient was noted to have 70% relief, but there was no documentation of the duration of relief, reduction in pain medications or functional benefit. The request for a caudal ESI is not medically necessary and appropriate.

A left shoulder subacromial 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, Shoulder Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 213.

Decision rationale: ACOEM Guidelines indicate that subacromial injections are recommended for subacute and chronic impingement syndrome, acute, subacute, and chronic shoulder pain, and for subacute and chronic rotator cuff tear. The clinical documentation submitted for review indicated the physician would like to perform a left shoulder subacromial injection to help delineate shoulder pain from the neck pain. The clinical documentation submitted for review failed to provide the exceptional factors, as the injection is generally not used to delineate shoulder pain from neck pain, to warrant nonadherence to guideline recommendations. The request for a left shoulder subacromial injection is not medically necessary and appropriate.

Trigger point injection: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 121-122.

Decision rationale: CA MTUS Guidelines recommend trigger point injections for myofascial pain syndrome. Additionally, it indicates the patient can have no repeat injections unless there is a greater than 50% relief obtained for 6 weeks after the injection and there is documented evidence of functional improvement. The patient was noted to have a previous injection on 7/03/2012, and the clinical documentation failed to provide the patient had 50% pain relief for 6 weeks after the injection with evidence of functional improvement. Additionally, the physical examination failed to provide the patient had documentation of circumscribed trigger points with

evidence upon palpation of a twitch response and referred pain. The request for trigger point injections is not medically necessary and appropriate.

A new TENS unit: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): s 115-116.

Decision rationale: California MTUS Guidelines recommend the ongoing use of a TENS with documentation of functional benefit. The clinical documentation submitted for review indicated the patient had a TENS unit that has ceased working and the TENS unit was noted to give the patient relief of her pain. However, the clinical documentation submitted for review failed to provide the functional benefit of the requested service. The request for a new TENS unit is not medically necessary and appropriate.

Lorazepam: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: California MTUS guidelines do not recommend benzodiazepines for long-term use because long term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks and the guidelines indicate that chronic benzodiazepines are the treatment of choice in very few conditions. The clinical documentation submitted for review failed to provide the efficacy of the requested medication. Additionally, it failed to provide the quantity and strength. The request for lorazepam is not medically necessary and appropriate.

Ambien CR: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Zolpidem.

Decision rationale: CA MTUS/ACOEM Guidelines do not address Ambien. Official Disability Guidelines indicate that zolpidem (Ambien) is a prescription short acting nonbenzodiazepine hypnotic used for short term, usually 2 weeks to 6 weeks, treatment of insomnia. The clinical documentation submitted for review failed to indicate the patient had signs and symptoms of

difficulty sleeping. The quantity being requested was not provided. Additionally, it failed to provide documentation of exceptional factors to warrant nonadherence to guideline recommendations. The request for Ambien CR is not medically necessary and appropriate.

Zanaflex: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants. .

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 66.

Decision rationale: California MTUS guidelines recommend tizanidine (Zanaflex®) as a non-sedating muscle relaxant with caution as a second line option for short term treatment of acute exacerbations in patients with chronic LBP. The clinical documentation submitted for review failed to provide the patient had trialed a first line option and failed to provide this would be a short term treatment for an exacerbation. Additionally, it failed to provide the quantity of the medication and strength being requested. The request for Zanaflex is not medically necessary and appropriate.

OxyContin: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Page(s): s 75, 78.

Decision rationale: California MTUS guidelines recommend long-acting opioids for around the clock pain relief and indicate it is not for as needed use. California MTUS recommend that there should be documentation of the 4 A's for ongoing monitoring including analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. The clinical documentation submitted for review failed to provide the documentation of the 4 A's. The request for OxyContin is not medically necessary and appropriate.

Oxycodone: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): s 75, 78.

Decision rationale: California MTUS guideline recommend oxycodone for controlling chronic pain and this medication is often used for intermittent or breakthrough pain. California MTUS recommend that there should be documentation of the 4 A's for ongoing monitoring including

analgesia, activities of daily living, adverse side effects and aberrant drug taking behavior. The clinical documentation submitted for review failed to provide documentation of the 4 A's to support ongoing use for this medication. Additionally, it failed to provide the strength and the quantity of the requested medication. The request for oxycodone is not medically necessary and appropriate.

Duragesic: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 44.

Decision rationale: California MTUS Guidelines do not recommend Duragesic as a first line therapy for pain. The clinical documentation submitted for review failed to provide the patient had tried other topical therapies for pain. Additionally, it failed to provide the number and the strength of the requested medication. The request for Duragesic is not medically necessary and appropriate.