

Case Number:	CM13-0028138		
Date Assigned:	03/14/2014	Date of Injury:	01/10/2007
Decision Date:	05/28/2014	UR Denial Date:	08/22/2013
Priority:	Standard	Application Received:	09/23/2013

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 Physical Medicine & Rehabilitation, and is licensed to practice in California. 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 an [REDACTED] employee who has filed a claim for back pain with radiculopathy to the left lower extremity associated with an industrial injury of January 10, 2007. Thus far, the patient has been treated with opioid and non-opioid analgesics, and steroid injections. The condition has been deemed permanent and stationary since August 03, 2010. Patient is unable to work. EMG (electromyography) performed in August 2010 showed moderate left L5 radiculopathy. Lumbar MRI and x-rays performed August 2010 showed lumbosacral spine disc disorder with radiculopathy of the left L5, which was also seen in the MRI performed April 2012 and October 2013. Medical records from 2013 through 2014 were reviewed showing the patient complaining of severe back pain. The patient has been taking Norco for the pain and has provided at least 50% functional improvement versus not taking any medication. The patient notes that injections give him great relief and enable him to resume some of the stretching exercises as instructed. The patient is unable to work and needs assistance with ADLs. On examination, the patient cannot stand up straight. There was presence of muscle spasms on palpation. Neurological exam for the lower extremities was mostly normal except for altered sensory loss at the left lateral calf and bottom of the foot. MRI of the lumbar spine from October 2013 and February 2014 demonstrated bilateral pars defect with anterolisthesis at L5-S1 with no significant detrimental change of the disc protrusion at L4-L5 and degree of spondylolisthesis at L4-L5 and L5-S1. In a utilization review report of August 22, 2013, the claims administrator denied a request for MRI of the lumbar spine as there was no significant change in the patient's condition since the last one performed April 2012; for epidural injection as patient had not been responsive to similar treatment in the past; and modified a request for Percocet 10/325mg #100 to #16 as patient is in the process of being weaned and according to the review dated July 2013, the patient had been tapered down to 20 tablets.

IMR ISSUES, DECISIONS AND RATIONALES

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

ONE (1) MRI OF THE LUMBAR SPINE BETWEEN 7/30/2013 AND 10/18/2013 IS NOT MEDICALLY NECESSARY AND APPROPRIATE.: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), LOW BACK CHAPTER, MRIS (MAGNETIC RESONANCE IMAGING).

Decision rationale: As noted on pages 303-304 of the MTUS ACOEM Guidelines, there is support for imaging of the lumbar spine in patients with red flag diagnoses where plain film radiographs are negative; unequivocal objective findings that identify specific nerve compromise on the neurologic examination, failure to respond to treatment, and consideration for surgery. The ODG guidelines recommend MRI for uncomplicated low back pain with radiculopathy after at least 1 month of conservative therapy. In this case, the employee is a candidate for neurosurgical consultation and needs an updated lumbar MRI no older than 6 months. There was already a lumbar MRI performed October 22, 2013 and, again, on February 14, 2014 that does not show significant changes from initial MRI findings. Therefore, the request for another lumbar MRI is not medically necessary.

ONE (1) EPIDURAL INJECTION BETWEEN 7/30/2013 AND 10/19/2013 IS NOT MEDICALLY NECESSARY AND APPROPRIATE.: 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), LOW BACK CHAPTER, EPIDURAL STEROID INJECTIONS (ESIs).

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

Decision rationale: As noted on page 46 of Chronic Pain Medical Treatment Guidelines, criteria for use of epidural steroid injections include radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing, and initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants. In this case, there is note of lumbar epidural steroid injection performed in May 2009. There is no documentation of the functional or symptomatic benefits. Also, there is also no documentation regarding use of different conservative management strategies such as physical therapy. The patient has been received IM morphine injections since July 2013 with noted symptomatic benefits 45 minutes after. Therefore, the request for lumbar epidural

steroid injection was not medically necessary according to the guideline recommendations of MTUS which were not met.

ONE (1) PRESCRIPTION OF PERCOCET 10/325 MG #100 BETWEEN 7/30/2013 AND 10/19/2013: 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): 79-81.

Decision rationale: As noted on page 79-81 of the Chronic Pain Medical Treatment Guidelines, there is no support for ongoing opioid treatment unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Opioids are not recommended for long-term use due to adverse risk and side effects. Percocet is a combination of oxycodone and acetaminophen, which is an analgesic that enhances the effect of oxycodone. In this case, the employee reports 50% improvement of symptoms and function with medications. Earliest authorization for Percocet according to progress notes was in August 2012 for #120. The employee is in the process of being weaned since May 07, 2013 with no objective documentation of improvement while on this medication. There is a modified certification for #12 instead of #100 dated October 09, 2013. The employee notes that amount of Percocet is not enough to keep him functional. Progress note dated December 03, 2013 noted that the employee self-procured Percocet and takes it 1-4 times a day. Progress note from January 29, 2014 states that the employee is on Norco, taking about 4 per day. This regimen is not consistent with a weaning process. Also, dosing regimen for both Percocet and Norco is not clearly documented and this is necessary for continued treatment with opioid medications. Therefore, the request for Percocet 10/325mg #100 was not medically necessary according to the guideline recommendations of MTUS Chronic Pain Medical Treatment Guidelines.