

<b>Case Number:</b>	CM13-0036019		
<b>Date Assigned:</b>	12/13/2013	<b>Date of Injury:</b>	04/25/2005
<b>Decision Date:</b>	02/07/2014	<b>UR Denial Date:</b>	10/10/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/18/2013

### 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 and 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 a 47-year-old male who reported an injury on 04/25/2005 due to a motor vehicle accident that caused injury to his low back. The patient was treated conservatively with epidural steroid injections, physical therapy and medications and ultimately underwent a lumbar laminectomy. The patient continued to have chronic pain with radicular symptoms that was managed with medications. The patient was regularly assessed for aberrant behavior with urine drug screens. The patient's most recent clinical examination findings included severe right leg pain with a positive straight leg raise test and decreased patellar reflex. It was also documented that the patient has pain along the ventral aspect of the right foot with limited active range of motion. The patient's diagnoses included postlaminectomy syndrome of the lumbar region, lumbago, thoracic lumbosacral neuritis/radiculitis and injury to the lumbosacral plexus. The patient's treatment plan included the continuation of medications and a transforaminal epidural steroid injection.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**One (1) repeat right L2, 4 TFE: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 24.

**Decision rationale:** The requested repeat right transforaminal epidural steroid injection at L2 and L4 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends repeat epidural steroid injections when there is greater than 50% pain relief and documentation of increased functional benefit and medication reduction for at least 6 to 8 weeks. The clinical documentation submitted for review does provide evidence that the patient previously received an epidural steroid injection in 02/2013. However, there was no quantitative evidence of pain reduction or evidence of medication reduction or functional improvement for at least 6 to 8 weeks after that injection. Therefore, an additional injection would not be supported. As such, the requested 1 repeat right L2 and L4 transforaminal epidural injection is not medically necessary or appropriate.

**Methadone 10mg, #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids On-Going Management Page(s): 78.

**Decision rationale:** The requested methadone 10 mg #90 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends documentation of a quantitative assessment of pain relief, specific evidence of functional improvement, management of side effects and monitoring of aberrant behavior to support the continued use of opioids in the management of a patient's chronic pain. The clinical documentation submitted for review does provide evidence that the patient is consistently monitored by urine drug screens. It is also noted within the documentation that the patient is able to work as tolerated as a result of medication usage. However, there was no documentation of a quantitative assessment evaluating the patient's pain relief as a result of the patient's continued opioid usage. Additionally, the clinical documentation indicates that the patient's medications allow the patient to continue to be active. However, it is also noted that the patient's pain limits the patient's ability to walk and sit for prolonged periods of time. Therefore, the patient's functional benefit of medication usage is not specifically identified. As such, the requested methadone 10 mg #90 is not medically necessary or appropriate.

**Fentora 600ugm, #56:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids On-Going Management Page(s): 78.

**Decision rationale:** The requested Fentora 600 1/4gm #56 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends documentation of a quantitative assessment of pain relief, specific evidence of functional improvement, management of side effects and monitoring of aberrant behavior to support the continued use of opioids in the management of a patient's chronic pain. The clinical documentation submitted for review does provide evidence that the patient is consistently monitored by urine drug screens. It is also noted within the documentation that the patient is able to work as tolerated as a result of medication usage. However, there was no documentation of a quantitative assessment evaluating the patient's pain relief as a result of the patient's continued opioid usage. Additionally, the clinical documentation indicates that the patient's medications allow the patient to continue to be active. However, it is also noted that the patient's pain limits the patient's ability to walk and sit for prolonged periods of time. Therefore, the patient's functional benefit of medication usage is not specifically identified. As such, the requested Fentora 600 1/4gm #56 is not medically necessary or appropriate.

**Oxycodone 20mg, #120:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids On-Going Management Page(s): 78.

**Decision rationale:** The requested oxycodone 20 mg #120 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends documentation of a quantitative assessment of pain relief, specific evidence of functional improvement, management of side effects and monitoring of aberrant behavior to support the continued use of opioids in the management of a patient's chronic pain. The clinical documentation submitted for review does provide evidence that the patient is consistently monitored by urine drug screens. It is also noted within the documentation that the patient is able to work as tolerated as a result of medication usage. However, there was no documentation of a quantitative assessment evaluating the patient's pain relief as a result of the patient's continued opioid usage. Additionally, the clinical documentation indicates that the patient's medications allow the patient to continue to be active. However, it is also noted that the patient's pain limits the patient's ability to walk and sit for prolonged periods of time. Therefore, the patient's functional benefit of medication usage is not specifically identified. As such, the requested oxycodone 20 mg #120 is not medically necessary or appropriate.