

Case Number:	CM13-0037574		
Date Assigned:	12/18/2013	Date of Injury:	11/12/1998
Decision Date:	05/05/2014	UR Denial Date:	10/10/2013
Priority:	Standard	Application Received:	10/23/2013

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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Interventional Spine 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 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/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 54-year-old female with a date of injury of 11/12/1998. The listed diagnoses per [REDACTED] are: 1. Lumbar degenerative disk disease. 2. Lumbar radiculitis. 3. Lumbar myofascial pain syndrome. According to report dated 09/20/2013 by [REDACTED], the patient presents with persistent low back pain and muscle spasms that have increased in the past month or so. She rates her pain level today as a 5 on a scale of 0 to 10. The medication does provide her "some dramatic relief of her functionality." The patient is requesting a lumbar epidural steroid injection. Patient reports prior injection provided greater than 15% relief of her low back pain and improved functionality of greater than 50% for the entire 3 months following the injection. Examination of the lumbar spine reveals flexion is 40 degrees; extension is 10 degrees with pain at extremes of range of motion. There is moderate tenderness to palpation at the distal right and left lumbar segments. Palpable spasms in these regions bilaterally were noted. There is a twitch response to palpation in the myofascial bands of the right and left distal lumbar segments. She has L5-S1 dermatomal distribution of dysesthesia in the bilateral lower extremities and a positive straight leg raise at 40 degrees bilaterally. She also has weakness with 3+/5 over bilateral peroneus longus. Patient's medication includes Ambien 10 mg, Percocet 10/325 mg, and Roxicodone 30 mg. The treater is requesting a refill of medications, 11 panel UDS, lumbar epidural steroid injection, epidurography, and fluoroscopy. MRI of the lumbar spine from 04/23/2013 states there are 1-2mm disc bulges at L3-L4 through L5-S1 with foramina and spinal canal.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE REQUEST FOR PRESCRIPTION OF AMBIEN 10MG #30

DOS:9/20/13: 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).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

Decision rationale: This patient presents with persistent low back pain and muscle spasms that have increased in the past month or so. The treater is requesting Ambien 10mg #30 stating, the patient suffers from insomnia and has difficulty sleeping at night due to her symptomatology. The MTUS and ACOEM Guidelines do not address Ambien; however, ODG Guidelines states that zolpidem (Ambien) is indicated for short-term treatment of insomnia with difficulty of sleep onset 7 to 10 days. In this case, medical records indicate the patient has not been prescribed Ambien in the past. A short course of 7 to 10 days may be indicated for insomnia; however, the treater is requesting 10mg #30. ODG Guidelines does not recommend long-term use of this medication, recommendation is for denial.

RETROSPECTIVE REQUEST FOR PRESCRIPTION OF PERCOCET 10/325MG #180

DOS 9/20/13: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 79-80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 80-82.

Decision rationale: This patient presents with persistent low back pain and muscle spasms that have increased in the past month or so. The treater is requesting Percocet 10/325mg for break through pain. For chronic opiate use, the MTUS Guidelines page 88 and 89 require functioning documentation using a numerical scale or a validated instrument at least once every six months. Documentation of the 4A (analgesia, ADLs, adverse side effects, and adverse behavior) are required. Furthermore under outcome measure, it also recommends documentation of current pain, average pain, least pain, time it takes for medication to work, duration of pain relief with medication, etc. Medical reports show that this patient has been Percocet since 10/23/2012. Monthly progress reports from 01/07/2013 to 09/20/2013 each state, medication provides some relief and on 09/20/2013 treater states, medications provide "some dramatic relief of her functionality." In this case, there are no discussions regarding any specific functional improvement to opiate use. Only generic states of "relief" are provided. None of the reports discuss any significant change in ADLs, change in work status, or return to work attributed to use of Percocet. MTUS require not only analgesia but documentation of ADL's and specific functional changes. Given the lack of sufficient documentation demonstrating efficacy from

chronic opiate use, the patient should now slowly be weaned as outlined in MTUS Guidelines. Recommendation is for denial.

**RETROSPECTIVE REQUEST FOR PRESCRIPTION OF ROXICODONE 30MG #180
DOS 9/20/13: Upheld**

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 79-80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 88-89.

Decision rationale: This patient presents with persistent low back pain and muscle spasms that have increased in the past month or so. For chronic opiate use, the MTUS Guidelines page 88 and 89 require functioning documentation using a numerical scale or a validated instrument at least once every six months. Documentation of the 4A (analgesia, ADLs, adverse side effects, and adverse behavior) are required. Furthermore under outcome measure, it also recommends documentation of current pain, average pain, least pain, time it takes for medication to work, duration of pain relief with medication, etc. Reports show this patient has been prescribed Oxycodone since 10/23/2012. The progress reports from 01/07/2013 to 09/20/2013 each states, medication provides "relief." In this case, there are no discussions regarding any specific functional improvement from Roxicodone use. None of the reports discuss any significant change in ADLs, change in work status, or return to work attributed to use of opiate use. MTUS requires not only analgesia but documentation of ADL's and functional changes. Given the lack of sufficient documentation demonstrating efficacy from chronic opiate use, the patient should now slowly be weaned as outlined in MTUS Guidelines. Recommendation is for denial.

**RETROSPECTIVE REQUEST FOR 11 PANEL URINE DRUG SCREEN DOS 9/20/13:
Upheld**

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 43.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 43.

Decision rationale: This patient presents with persistent low back pain and muscle spasms that have increased in the past month or so. The treater is requesting an 11 panel drug screen. While MTUS Guidelines do not specifically address how frequent UDS should be obtained for various risks of opiate users, ODG Guidelines provide clearer recommendation. It recommends once yearly urine screen following initial screening with the first 6 months for management of chronic opiate use in low risk patient. In this case, medical records indicate the patient has had prior inconsistent urine drug screens from 10/12/2013 and 02/2013. However, subsequent tests administered on 03/28/2013, 04/12/2013 and 09/20/2013 were all consistent with the medication prescribed. Given the patient has had 3 consecutive consistent urine drug screens, such frequent

testing are not necessary. ODG recommends once yearly for low risk patients. Recommendation is for denial.

Lumbar Epidural Steroid Injection QTY:1.00: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46-47.

Decision rationale: This patient presents with persistent low back pain and muscle spasms that have increased in the past month or so. The treater is requesting a Lumbar epidural steroid injection at L5-S1. The MTUS Guidelines page 46 and 47 recommends "ESI as an option for treatment of radicular pain defined as pain in dermatomal distribution with corroborative findings of radiculopathy." For repeat injections during therapeutic phase, "continued objective documented pain and functional improvement including at least 50% pain relief with associated reduction of medication for 6 to 8 weeks with a general recommendation of no more than 4 blocks per year." As medical records document, the patient underwent a lumbar ESI on 10/10/2012. The treater in his 09/20/2013 report state, the patient received 15% pain relief, and 50% improvement in functionality for the entire 3 months following the injection. Three month of progress reports following the 10/10/2012 ESI were reviewed. Report from 11/28/2012, 01/07/2013 and 02/06/2013 provides no indication that the patient received any relief from the ESI. In fact, the treater notes patient continues with persistent pain with soreness that radiates into lower extremities and reports pain level consistently at 6-7/10. For repeat injections there must be document of pain and functional improvement. Recommendation is for denial.

Epidurography QTY 1.00: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46-47.

Decision rationale: This patient presents with persistent low back pain and muscle spasms that have increased in the past month or so. She also complains of persistent left knee pain. The treater is requesting an ESI and Epidurography. The MTUS guidelines pages 46, 47 recommends ESI as an option "for treatment of radicular pain defined as pain in dermatomal distribution with collaborating findings on imaging studies." For repeat injections during therapeutic phase, "continued objective documented pain and functional improvement including at least 50% pain relief with associated reduction of medication for 6 to 8 weeks with a general recommendation of no more than 4 blocks per year." In this case, the patient did not obtain 50% pain and functional improvement from the prior injection. Given the patient does not meet the criteria for an ESI, the requested Epidurography is not medically necessary and recommendation is for denial.

Fluoroscopic QTY:1.00: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46-47.

Decision rationale: This patient presents with persistent low back pain and muscle spasms that have increased in the past month or so. The treater is requesting an ESI with fluoroscopy. The MTUS guidelines pages 46, 47 recommends ESI as an option "for treatment of radicular pain defined as pain in dermatomal distribution with collaborating findings on imaging studies." For repeat injections during therapeutic phase, "continued objective documented pain and functional improvement including at least 50% pain relief with associated reduction of medication for 6 to 8 weeks with a general recommendation of no more than 4 blocks per year." In this case, the patient did not obtain 50% pain and functional improvement from the prior injection. Given the patient does not meet the criteria for an ESI, the requested fluoroscopy is not medically necessary and recommendation is for denial.