MAXIMUS Federal Services

Case Number:	CM13-0053516		
Date Assigned:	12/30/2013	Date of Injury:	01/10/2007
Decision Date:	03/18/2014	UR Denial Date:	11/05/2013
Priority:	Standard	Application Received:	11/18/2013

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 Physicial Medicine & Rehabilitation and is licensed to practice in Illinois. 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 41 year old male who reported an injury on 01/10/2007 after the patient was rammed by a machine while performing normal job duties and reportedly sustained an injury to his low back. This ultimately resulted in an interbody lumbar fusion from the L3 to the S1 followed by hardware removal in 2010 and spinal cord stimulator implantation. The patient developed chronic pain that was managed by medications to include Norco 10/325 mg, Ambien, Prilosec, Neurontin, Anaprox, Trazodone, Valium, Wellbutrin, medical marijuana, and Dendracin topical analgesic cream. The patient underwent a CT of the lumbar spine in 05/2013 that revealed an incomplete fusion at the L2-3 and a disc space fusion cage at the L5-S1 with no evidence of disc protrusion, central canal stenosis, or neural foraminal stenosis. The patient was also treated with trigger point injections and monitored for medication compliance with urine drug screens. The patient's most recent clinical evaluation revealed the patient had complaints of radicular symptoms in the bilateral lower extremities and tenderness in the posterior lumbar musculature with decreased range of motion and a positive bilateral straight leg raising test, sensory deficits noted within the L5-S1 distribution. The patient's diagnoses included lumbar disc degenerative disease with spondylolisthesis, bilateral lower extremity radiculopathy, and medication induced gastritis, sleeping difficulties, and reactionary depression anxiety. The patient's treatment plan included an intrathecal narcotic, bilateral S1 transforaminal epidural steroid injections, continuation of medications, and continuation of cognitive behavioral therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral S1 Transforaminal Epidural Steroid Injection: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Page(s): 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 78.

Decision rationale: The requested Bilateral S1 Transforaminal Epidural Steroid Injection is not medically necessary or appropriate. The California Medical Treatment and Utilization Schedule recommends epidural steroid injections for patients who have radicular complaints that are supported by physical findings and corroborated by an imaging study and/or an electrodiagnostic study that have been recalcitrant to conservative therapy. The clinical documentation submitted for review does provide evidence that the patient has decreased sensation in the L5-S1 dermatome with a bilateral straight leg raising test. Although and EMG is referenced within body of the most recent clinical note that would support the patient's radicular symptoms, an independent report of that study was not provided for review. Therefore the findings cannot be verified. Also, the most recent CT evaluation of the lumbar spine did not provide any evidence of nerve root involvement to support an epidural steroid injection. Additionally, there is no documentation that the patient is currently participating in any type of active therapy that may assist with pain relief. Therefore, the need for a S1 transforaminal epidural steroid injection is not clearly established. As such, the requested Bilateral S1 Transforaminal Epidural Steroid Injection is not medically necessary or appropriate.

Norco 10/325mg #240 dispensed in the office: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Page(s): 78.

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

Decision rationale: The requested Norco 10/325mg #240 dispensed in the office is not medically necessary or appropriate. The California Medical Treatment and Utilization Schedule recommends that the continued use of opioids in the management of chronic pain be supported by a quantitative assessment of pain relief, documentation of functional benefit, managed side effects, and evidence that the patient is evaluated for compliance to the prescribed medication schedule. The clinical documentation submitted for review does provide evidence that the patient is regularly monitored for compliant behavior with urine drug screens. However, the patient's most recent evaluations fail to document a quantitative assessment of pain relief or document functional benefit. Therefore, the efficacy of this medication cannot be established. As such, the requested Norco 10/325mg #240 dispensed in the office is not medically necessary or appropriate.

OxyContin 40mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Page(s): 78.

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

Decision rationale: The requested OxyContin 40mg #90 is not medically necessary or appropriate. The California Medical Treatment and Utilization Schedule recommends that the continued use of opioids in the management of chronic pain be supported by a quantitative assessment of pain relief, documentation of functional benefit, managed side effects, and evidence that the patient is evaluated for compliance to the prescribed medication schedule. The clinical documentation submitted for review does provide evidence that the patient is regularly monitored for compliant behavior with urine drug screens. However, the patient's most recent evaluations fail to document a quantitative assessment of pain relief or document functional benefit. Therefore, the efficacy of this medication cannot be established. As such, the requested OxyContin 40mg #90 is not medically necessary or appropriate.