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| Case Number: | CM14-0000624 | | |
| Date Assigned: | 01/10/2014 | Date of Injury: | 04/14/2001 |
| Decision Date: | 04/22/2014 | UR Denial Date: | 12/26/2013 |
| Priority: | Standard | Application Received: | 01/02/2014 |

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 Occupational Medicine 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:

Prior treatment history has included Roxicodone 15 mg 3 times a day. The patient underwent a lumbar epidural steroid injection at L5-S1, right paramedian interlaminar approach with epidurogram under fluoroscopy on 01/25/2013; lumbar epidural steroid injection at L4-L5, left paramedian interlaminar approach with epidurogram under fluoroscopy on 05/26/2009. He underwent a caudal epidural steroid injection under fluoroscopy, caudal catheter placement, infusion through the epidural catheter, and epidurogram on 11/02/2007. Medications Include: OxyContin 30 mg 3 times a day, Roxicodone 15 mg 3 times a day, Zofran 8 mg tablets 1 per day, Relpax 20 mg q. day. Diagnostic studies reviewed include MRI showed multiple areas of neuralforaminal narrowing L1-S1. There was severe central canal narrowing at L3-4 and moderate severe central canal narrowing at L4-5. There was trefoil appearance of the ligamentum flavum with hypertrophy at these levels. MRI of the lumbar spine without contrast performed on 10/30/2006 revealed multilevel spondylosis results in moderate spinal canal stenosis at L4-5, mild to moderate spinal canal stenosis at L5-S1 and mild spinal canal stenosis at T11-12, L1-2, L2-3 and L3-4, with multilevel neural foraminal, most severe on the left at L1-2. Drug Adherence Report dated 04/18/2013 indicated Roxicodone and oxycodone tested positive. Drug Adherence Report dated 11/26/2012 indicated Oxycontin and oxycodone tested positive Office note dated 12/12/2013 documented the patient to have complaints of severe low back, buttock and leg pain. The patient was reported to be on chronic medications from which he received good steady state of relief. The patient reported a significant flare of his low back pain with radiation into his lower extremities. Since the patient reported continued pain and symptoms of spinal stenosis, a MRI of the lumbar spine without contrast was ordered. Objective findings on exam revealed pain with manipulation of his lumbar spine all planes. There was pain with 30 degrees of flexion and 10 degrees of extension. He had positive straight leg raises in the sitting

position with pain in the lumbosacral spine into the posterior upper leg. He was unable to walk heel to toe. He had an antalgic gait. Myofasciitis extended from L2 down into the sacrum with significant muscle spasm. There were no new motor or sensory deficits. The recommendation for this patient was to request an authorization for a lumbar spine epidural steroid injection to reduce radiculopathy symptoms and increased pain. Office note dated 02/25/2013 documented the patient to have complaints of severe low back, buttock, and leg pain. The patient was being followed on chronic medications from which he received good steady state relief. The patient reported significant flare of his low back pain with radiation into his lower extremities. The patient reported good results of 70% relief from his last injection on 01/25/2013. He stated the pain was relieved and has now returned. The pain has responded well to epidural injections in the past and I recommend this treatment as medically indicated. Objective findings on exam revealed pain with manipulation of his lumbar spine in all planes. There was pain with 30 degrees of flexion and 10 degrees of extension. He had positive straight leg raises in the sitting position with pain in the lumbosacral spine into the posterior upper leg. He was unable to walk heel to toe. He had an antalgic gait. There was myofasciitis extension from L2 down into the sacrum with significant muscle spasm. The patient was recommended Oxycontin and Roxicodone; and a request for an authorization for a repeat lumbar epidural steroid injection, transforaminal approach. This would be reduce the inflammation that was causing the increase in pain in his low back and lower extremities. These injections had been effective for the patient in the past giving him relief for over a year.

IMR ISSUES, DECISIONS AND RATIONALES

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

LUMBAR EPIDURAL STEROID INJECTION UNDER FLUOROSCOPY: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: Chronic Pain Medical Treatment Guidelines (May 2009), Corticosteroid and Epidural Injections.

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

Decision rationale: According to the CA MTUS Guidelines, ESI is recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). A second epidural injection is recommended if partial success is produced with the first injection and a third ESI is rarely recommended. Epidural steroid injection can offer short term pain relief, and use should be in conjunction with other rehab efforts, including continuing a home exercise program, epidural steroid injections may lead to an improvement in radicular lumbosacral pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months. The medical records document that the patient has degenerative disc disease and spondylosis of the lumbar spine. The patient received 3 ESIs in the past, the last one dated 1/25/2013 in which there was a 70% reduction in pain. But 4 weeks after the injection, the patient had a significant flare up of low back pain as reported on 2/25/2013. Pain relief should last 6-8 weeks to warrant repeat injection. Furthermore, specific nerve root compromise is

not clearly demonstrated. Recent symptoms and physical examination lack specifics. Lumbar MRI does not make mention of nerve impingement. Medical necessity has not been established. Therefore, lumbar ESI is non-certified.

ROXICODONE 15MG #90: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: Chronic Pain Medical Treatment Guidelines (May 2009), Opioids for Chronic Pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 75, 80, 92,124.

Decision rationale: According to the CA MTUS Guidelines, Roxicodone "Oxycodone" is known as "normal-release" or "immediate-release" opioid recommended for short-term pain relief, and long-term efficacy is unclear (16 weeks), but also appears limited. Failure to respond to a time-limited course of opioids has led to the suggestion of reassessment and consideration of alternative therapy. Long-term use of opioids for chronic pain has not been shown to improve pain, function, or quality of life. The medical records document the patient is diagnosed with degenerative disc disease of the lumbar spine and has been on Roxicodone since January 2013. The patient continues to have severe pain and decreased function. Functional improvement and pain reduction attributable to Roxicodone have not been established in the available medical records. Therefore, Roxicodone is non-certified.