

Case Number:	CM14-0001236		
Date Assigned:	04/02/2014	Date of Injury:	08/14/1983
Decision Date:	06/30/2014	UR Denial Date:	12/26/2013
Priority:	Standard	Application Received:	01/03/2014

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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in California and Nevada. 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 57 year old female injured on 08/14/83 due to an undisclosed mechanism of injury. Neither the specific injury sustained nor the initial treatments rendered were addressed in the clinical documentation submitted for review. The most recent clinical note dated 02/13/14 indicates the patient was status post lumbar reconstructive surgery L5-S1 with adjacent segment compromise and disc disruption at L3-4 with facet arthropathy, previously improved through caudal epidural steroid injection now gradually returning. The patient presented complaints of severe low back pain radiating into bilateral lower extremities unchanged from the previous visit rated at 8/10 on VAS. There were no new focal dermatomal or myotomal deficits appreciated. The patient ambulated with forward flexed gait, sitting with forward flexed posture using bilateral upper extremities to support her torso. The patient utilized a cane for ambulation. Caudal epidural steroid injection performed on 07/12/13 provided 30% reduction in pain relief for approximately one month. Medications as of 02/13/14 included Morphine Sulfate ER 30mg BID, Norco 10mg Q6 hours, Neurontin 300mg Q8 hours, Zanaflex 4mg TID, and Restoril 30mg QHS.

IMR ISSUES, DECISIONS AND RATIONALES

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

CAUDAL EPIDURAL STEROID INJECTION: 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, EPIDURAL STEROID INJECTIONS, 46

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, 9792.20, EPIDURAL STEROID INJECTIONS (ESIS), 46

Decision rationale: The Chronic Pain Medical Treatment Guidelines, epidural steroid injections are recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). The physical exam lacked compelling objective data to substantiate a radicular pathology. The MTUS guidelines state that radiculopathy must be documented and objective findings on examination need to be present. Additionally, Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing. In this case, there were no official imaging reports submitted for review. Repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks. The documentation indicated the caudal epidural steroid injection performed on 07/12/13 provided 30% reduction in pain relief for approximately one month. As such, the request for caudal epidural steroid injection is not medically necessary and appropriate.

OPANA EXTENDED RELEASE 20 MG #60: 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, OPIOIDS, 93

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES 9792.20, OPIOIDS, CRITERIA FOR USE, 77

Decision rationale: The Chronic Pain Medical Treatment Guidelines, state that patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. In this case, there is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. The patient consistently rated her pain at elevated levels indicated a lack of medication efficacy. In addition, no recent opioid risk assessments regarding possible dependence or diversion were available for review. Moreover, there were no recent urine drug screen reports made available for review. Therefore, the request for Opana Extended Release 20 mg #60 is not medically necessary and appropriate.

DILAUDID 2 MG #60: 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, OPIOIDS, 51,93

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES 9792.20, OPIOIDS, CRITERIA FOR USE, , 77

Decision rationale: The Chronic Pain Medical Treatment Guidelines, states that patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. In this case, there is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. The patient consistently rated her pain at elevated levels indicated a lack of medication efficacy. In addition, no recent opioid risk assessments regarding possible dependence or diversion were available for review. Moreover, there were no recent urine drug screen reports made available for review. Therefore, the request for Dilaudid 2 mg #60 is not medically necessary and appropriate.

RESTORIL 30 MG #30: 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, BENZODIAZEPINES, 24,66

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, 9792.20, BENZODIAZEPINES, , 24

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines, state that benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. A more appropriate treatment for anxiety disorder is an antidepressant. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks. In this case, the patient has exceeded the 4 week treatment window. As such, the request for Restoril 30 MG #30 is not medically necessary and appropriate.

NORCO 10/325 MG #120: 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, OPIOIDS, 91

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES 9792.20, OPIOIDS, CRITERIA FOR USE, , 77

Decision rationale: According to the MTUS Chronic Pain Medical Treatment Guidelines, patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. The patient consistently rated her pain at elevated levels indicated a lack of medication efficacy. In addition, no recent opioid risk assessments regarding possible dependence or diversion were available for review. Moreover, there were no recent urine drug screen reports made available for review. Therefore, the request for Norco 10/325 mg #120 is not medically necessary and appropriate.