

Case Number:	CM14-0004109		
Date Assigned:	02/03/2014	Date of Injury:	06/05/2002
Decision Date:	06/20/2014	UR Denial Date:	01/02/2014
Priority:	Standard	Application Received:	01/09/2014

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 Physical 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 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 injured worker is a 56 year old female with a reported injury date on 06/07/2002; the mechanism of injury was not provided. The clinical note dated 04/10/2014 noted that the injured worker had complaints that included 7/10 pain to the lower back and left lower extremity that have been increasing. Additional complaints included increased cramping and sharp spasms to the left lower extremity that kept the injured worker awake at night and caused the injured worker to trip resulting in the need for the injured worker to use her cane. Objective findings included tenderness to the distal spine bilaterally, positive straight leg raise left lower extremity, and diminished sensation along the L4-S1 dermatomes. The injured workers medication regimen included Duragesic patches, Norco, and Ambien since at least 01/03/2013. It was noted that a prior left L4-L5 transforaminal epidural steroid injection (05/16/2013) had a 60 to 70 percent reduction of the injured workers symptomatology for at least six months. The request for authorization for bilateral L4-L5 transforaminal epidural steroid injection was submitted on 12/21/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

REPEAT LEFT L4-L5 EPIDURAL STEROID INJECTION: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection.

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

Decision rationale: The request for a repeat left L4-L5 epidural steroid injection is not medically necessary. It was noted that the injured worker had 7/10 pain to the lower back and left lower extremity that have been increasing. Additional complaints included increased cramping and sharp spasms to the left lower extremity. Objective findings included tenderness to the distal spine bilaterally, positive straight leg raise left lower extremity, and diminished sensation along the L4-S1 dermatomes. It was noted that a prior left L4-L5 transforaminal epidural steroid injection (05/16/2013) had a 60 to 70 percent reduction of the injured workers symptomatology for at least six months. The California MTUS guidelines recommend the use of epidural steroid injections for the treatment of radicular pain and repeat blocks can be used if there is continued documentation of pain and functional improvement, to include at least 50% pain relief with associated reduction of medication use for six to eight weeks. Additionally, the guidelines state that imaging studies must corroborate radicular symptoms found upon examination. Although the documentation noted that the injured worker received 60 to 70 percent reduction in symptomatology there was a lack of quantifiable evidence that the prior injection resulted in functional improvement to include reduction of overall medication use. Additionally, the requesting physician did not include an official MRI of the lumbar spine within the clinical documentation. Furthermore, it was unclear if the injured worker has had any recent conservative care as the last injection was performed 12 months prior. As such this request is not medically necessary.

BILATERAL LUMBAR EPIDURAL STEROID INJECTION L4-L5: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection.

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

Decision rationale: The request for a bilateral lumbar epidural steroid injection L4-L5 is not medically necessary. It was noted that the injured worker had 7/10 pain to the lower back and left lower extremity that have been increasing. Additional complaints included increased cramping and sharp spasms to the left lower extremity. Objective findings included tenderness to the distal spine bilaterally, positive straight leg raise left lower extremity, and diminished sensation along the L4-S1 dermatomes. It was noted that a prior left L4-L5 transforaminal epidural steroid injection (05/16/2013) had a 60 to 70 percent reduction of the injured workers symptomatology for at least six months. The California MTUS guidelines state that epidural steroid injections are recommended as an option for the treatment of radicular pain when radiculopathy is documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing, the injured worker is initially unresponsive to conservative treatment, and injections should be performed using fluoroscopy (live x-ray) for guidance. The medical necessity of this request has not been established. There is no symptomatology to suggest that the injured worker is experiencing right sided radiculopathy. Additionally, the requesting physician did not include

an official MRI of the lumbar spine within the clinical documentation. As such this request is not medically necessary.

AMBIEN 10 MG: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Ambien for Chronic Pain, as well as MedScape 2009 and PDR 2009.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Zolpidem (Ambien).

Decision rationale: The request for Ambien 10mg is not medically necessary. It was noted that the injured worker had complaints that included 7/10 pain the lower back and left lower extremity. Additional complaints included increased cramping and sharp spasms to the left lower extremity that keeps the injured worker awake at night. It was also noted that the injured worker had been prescribed Ambien since at least 01/03/2013. The Official Disability Guidelines state that Zolpidem is approved for the short-term (usually two to six weeks) treatment of insomnia as they can be habit-forming, may impair function and memory and can increase may increase pain and depression over the long-term. It was noted that the injured worker has been prescribed this medication for a long period of time approximately 15 months which exceeds the recommended timeframe if 2 to 6 weeks. Additionally, there is a lack of evidence that the medication provided the desired therapeutic effect. As such this request is not medically necessary.

DURAGESIC PATCH 25 MCG PATCH: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Long-Acting Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic (Fentanyl Transdermal System) Page(s): 44.

Decision rationale: The request for Duragesic Patch 25mcg patch is not medically necessary. It was noted that the injured worker had complaints of 7/10 pain the lower back and left lower extremity that have been increasing. Additional complaints included increased cramping and sharp spasms to the left lower extremity. The injured workers medication regimen included Duragesic patches, Norco, and Ambien since at least 01/03/2013. The California MTUS guidelines do not recommend Duragesic as a first-line therapy. It is indicated for the management of chronic pain in patients who require continuous opioid analgesia for pain that cannot be managed by other means. The medical necessity for the use of this medication was not established. There is a lack of quantifiable evidence that the requested medication provided the injured worker with significant therapeutic effects to include functional improvement, improved pain level, and the ability for the injured worker to return to work. Additionally, it was noted that the injured worker has been taking Norco regularly for breakthrough pain as well as other strengths of the duragesic patch; therefore, the injured workers daily morphine equivalent dose

would exceed the recommendation for 120 MEQ. Furthermore, the request remains unclear as the frequency was not provided. As such this request is not medically necessary.

DURAGESIC PATCH 12 MCG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Long-Acting Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic (Fentanyl Transdermal System).

Decision rationale: The request for Duragesic Patch 12mcg patch is not medically necessary. It was noted that the injured worker had complaints of 7/10 pain the lower back and left lower extremity that have been increasing. Additional complaints included increased cramping and sharp spasms to the left lower extremity. The injured workers medication regimen included Duragesic patches, Norco, and Ambien since at least 01/03/2013. The California MTUS guidelines do not recommend Duragesic as a first-line therapy. It is indicated for the management of chronic pain in patients who require continuous opioid analgesia for pain that cannot be managed by other means. The medical necessity for the use of this medication was not established. There is a lack of quantifiable evidence that the requested medication provided the injured worker with significant therapeutic effects to include functional improvement, improved pain level, and the ability for the injured worker to return to work. Additionally, it was noted that the injured worker has been taking Norco regularly for breakthrough pain as well as other strengths of the duragesic patch; therefore, the injured workers daily morphine equivalent dose would exceed the recommendation for 120 MEQ. Furthermore, the request remains unclear as the frequency was not provided. As such this request is not medically necessary.

FENTANYL 50: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Long-acting opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic (Fentanyl Transdermal System) Page(s): 44.

Decision rationale: The request for Fentanyl 50 is not medically necessary. It was noted that the injured worker had complaints of 7/10 pain the lower back and left lower extremity that have been increasing. Additional complaints included increased cramping and sharp spasms to the left lower extremity. The injured workers medication regimen included Duragesic patches, Norco, and Ambien since at least 01/03/2013. The California MTUS guidelines do not recommend Fentanyl as a first-line therapy. It is indicated for the management of chronic pain in patients who require continuous opioid analgesia for pain that cannot be managed by other means. There is a lack of quantifiable evidence that the requested medication provided the injured worker with significant therapeutic effects to include functional improvement, improved pain level, and the ability for the injured worker to return to work. Additionally, it was noted that the injured worker has been taking Norco regularly for breakthrough pain as well as other strengths of the duragesic

patch; therefore, the injured workers daily morphine equivalent dose would exceed the recommendation for 120 MEQ. Additionally, the request does not provide the frequency that the requested medication is to be given. As such this request is not medically necessary.

NORCO: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines On-going Opioid Use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78-80.

Decision rationale: The request for Norco is not medically necessary. It was noted that the injured worker had complaints of 7/10 pain the lower back and left lower extremity that have been increasing. Additional complaints included increased cramping and sharp spasms to the left lower extremity. The injured workers medication regimen included Duragesic patches, Norco, and Ambien since at least 01/03/2013. The California MTUS guidelines state that on-going management of pain relief with opioids must include ongoing review and documentation of adequate pain relief, functional status, appropriate medication use, and side effects. There is a lack of quantifiable evidence that the requested medication provided the injured worker with significant therapeutic effects to include functional improvement, improved pain level, and the ability for the injured worker to return to work. Additionally, it was noted that the injured worker has been taking Norco regularly for breakthrough pain as well as other strengths of the duragesic patch; therefore, the injured workers daily morphine equivalent dose would exceed the recommendation for 120 MEQ. Additionally, the request remains unclear as the dosage and frequency was not provided. As such this request is not medically necessary.