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| Case Number: | CM14-0011343 | | |
| Date Assigned: | 02/21/2014 | Date of Injury: | 05/01/2002 |
| Decision Date: | 09/09/2014 | UR Denial Date: | 01/23/2014 |
| Priority: | Standard | Application Received: | 01/28/2014 |

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:

The patient is a 57-year-old female who has filed a claim for lumbosacral disc degeneration associated with an industrial injury date of May 01, 2002. Review of progress notes indicates improvement of the low back and right lower extremity pain with physical therapy, exercise, and medications. Findings include decreased motor strength of the right EHL, decreased right lower extremity reflexes, decreased lumbar range of motion, and positive straight leg raise test bilaterally. Mention of a lumbar MRI from mid-2011 showed solid fusion L5-S1 and mild degenerative changes at L2-3 and L1-2. Treatment to date has included physical therapy, chiropractic therapy, gabapentin, opioids, muscle relaxants, antidepressants, sedatives, lumbar epidural steroid injections, facet injections, and lumbar spinal surgeries. Utilization review from January 22, 2014 denied the requests for right TFE injection L4-L5-S1 and AFO brace as this was previously certified. There was modified certification for oxycodone 30mg for #90, oxycontin 40mg for #90, oxycontin 80mg for #60, and Duragesic 100mcg for #15 as the patient is taking opioids in an amount that exceeds guideline recommendations.

IMR ISSUES, DECISIONS AND RATIONALES

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

ONE RIGHT TRANSFORAMINAL EPIDURAL STEROID INJECTION L4-L5-S1:

Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines EPIDURAL STEROID INJECTIONS (ESIS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines : Epidural steroid injections ESIS Page(s): 46.

Decision rationale: As stated on page 46 of CA MTUS Chronic Pain Medical Treatment Guidelines, there is no support for epidural injections in the absence of objective radiculopathy. Criteria for the use of epidural steroid injections include an imaging study documenting correlating concordant nerve root pathology and conservative treatment. Repeat blocks should only be offered if there is at least 50% pain relief for six to eight weeks following previous injection, with a general recommendation of no more than 4 blocks per region per year. This patient had several lumbar epidural steroid injections in the past, the latest one in August 2013 for the right L3 and L4. Progress notes indicate 100% relief of right lower extremity pain and 50% relief of back pain lasting 3 days. In this case, there is no documentation of recent imaging findings consistent with lumbar radiculopathy. Also, the indication for repeat blocks has not been met, as there was no documentation the levels injected and benefits derived from the several previous blocks. Therefore, the request for right transforaminal epidural steroid injection L4-L5-S1 was not medically necessary.

ANKLE/ FOOT ORTHOSIS (AFO) BRACE: 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), Ankle and Foot (Acute & Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Ankle and Foot chapter, Ankle foot orthosis (AFO).

Decision rationale: The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, ODG was used instead. According to ODG, ankle foot orthosis is recommended for foot drop, and for surgical or neurological recovery. In this case, there is no documentation clearly describing that the patient has foot drop. Progress notes indicate that the patient has been tripping over the right foot, which has improved with medications and physical therapy. There is no clear indication for the use of this orthosis. Therefore, the request for AFO brace was not medically necessary.

OXYCODONE 30MG #120 WITH 5 REFILLS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, CRITERIA FOR USE.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines : Opioids, criteria for use; On-Going Management Page(s): 78-82.

Decision rationale: As noted on pages 78-82 of the CA MTUS Chronic Pain Medical Treatment Guidelines, there is no support for ongoing opioid treatment unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Patient has been on this medication since 2012. There is no documentation regarding symptomatic improvement or objective functional benefits derived from this medication. Also, the patient is taking amounts of opioids that greatly exceed the guideline recommendation of 120 MED daily. Additional refills are not indicated unless the criteria for ongoing use have consistently been met. Therefore, the request for oxycodone 30mg #120 with 5 refills was not medically necessary.

OXYCONTIN 40MG #90 WITH 5 REFILLS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, CRITERIA FOR USE.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines : Opioids, criteria for use; On-Going Management Page(s): 78-82.

Decision rationale: As noted on pages 78-82 of the CA MTUS Chronic Pain Medical Treatment Guidelines, there is no support for ongoing opioid treatment unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Patient has been on this medication since 2012. There is no documentation regarding symptomatic improvement or objective functional benefits derived from this medication. Also, the patient is taking amounts of opioids that greatly exceed the guideline recommendation of 120 MED daily. Additional refills are not indicated unless the criteria for ongoing use have consistently been met. Therefore, the request for oxycontin 40mg #90 with 5 refills was not medically necessary.

OXYCONTIN 80MG #90 WITH 5 REFILLS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS, CRITERIA FOR USE.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines : Opioids, criteria for use; On-Going Management Page(s): 78-82.

Decision rationale: As noted on pages 78-82 of the CA MTUS Chronic Pain Medical Treatment Guidelines, there is no support for ongoing opioid treatment unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Patient has been on this medication since 2012. There is no documentation regarding symptomatic improvement or objective functional benefits derived from this medication. Also, the patient is taking amounts of opioids that greatly exceed the guideline recommendation of 120 MED daily. Additional refills are not indicated unless the criteria for ongoing use have consistently been met. Therefore, the request for oxycontin 80mg #90 with 5 refills was not medically necessary.

DURAGESIC 100MCG #15 WITH 5 REFILLS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines WEANING OF MEDICATIONS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines : Duragesic (fentanyl transdermal system) Page(s): 44.

Decision rationale: Duragesic is at fentanyl transdermal therapeutic system. As noted in page 44 of CA MTUS chronic pain medical treatment guidelines, Duragesic is indicated in management of chronic pain in patients who require continuous opioid analgesia for pain that cannot be managed by other means. Patient has been on this medication since 2012. There is no documentation regarding symptomatic improvement or objective functional benefits derived from this medication. Also, the patient is taking amounts of opioids that greatly exceed the guideline recommendation of 120 MED daily. Additional refills are not indicated unless the criteria for ongoing use have consistently been met. Therefore, the request for Duragesic 100mcg #15 with 5 refills was not medically necessary.