

Case Number:	CM14-0017654		
Date Assigned:	04/16/2014	Date of Injury:	12/29/2002
Decision Date:	06/03/2014	UR Denial Date:	01/28/2014
Priority:	Standard	Application Received:	02/12/2014

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 Physical Medicine and Rehabilitation 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 36-year-old female who was injured on 12/29/2002. The mechanism of injury is unknown. Prior treatment history has included nerve blocks/injections, epidural steroids, and chiropractic treatment; home exercise program, moist heat, and stretches. The patient's medications as of 03/14/2014 include: Dilaudid 4 mg tabs, Fentanyl 50 mcg/hr, Lyrica 50 mg caps, Zanaflex 4 mg, Viramune 200 mg tabs, and Neurontin 600 mg tabs. Progress report dated 03/14/2014 states the patient presents with complaints of low back pain radiating into the left lower extremity which interferes with function. She rated her pain previously a 5 on a good day; at this visit, she rates it as 5 on a good day. On exam, the neck range of motion is normal. There is severe tenderness over the cervical area bilaterally and limited range of motion is all directions. There is tenderness over the paracervical, trapezius and rhomboid area. The lumbar spine reveals tenderness over the left lower lumbar area. Straight leg raise is positive at 25 degrees on the left side and range of motion is limited due to pain. She has an antalgic gait, moves very slow and limps on the left side. She has weakness diffusely in both lower extremities and left hand grip weakness. On sensory exam, there is decreased sensation at left L5 and at left S1 and decreased sensation in bilateral lower extremities. Deep tendon reflexes in the upper and lower extremities are decreased but equal. The assessment and plan is left lumbar radiculopathy, left sacroiliac joint dysfunction; spinal cord stimulation (SCS) lumbar implant; failed back surgery syndrome; left cervical radiculopathy; occipital neuralgia; major depression; myofascial pain syndrome; and right shoulder impingement syndrome.

IMR ISSUES, DECISIONS AND RATIONALES

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

CAUDAL EPIDURAL INJECTION UNDER FLUOROSCOPIC WITH ANESTHESIA:
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 Page(s): 46.

Decision rationale: According to the guidelines, for a patient to be considered a candidate for epidural steroid injection there must be radiculopathy documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. The progress report dated 3/14/2014 documents subjective report and objective examination findings that are unchanged in all the previous follow-ups. There is no indication of any change or worsening in the patient's subjective or objective findings. Furthermore, the medical records do not reveal corroborative imaging or electrodiagnostic evidence of active radiculopathy. The medical necessity of the request is not established.

PRESCRIPTION FOR PERCOCET 10/325MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, specific drug list Page(s): 74-96, 74-80.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, continued opioid treatment requires documented pain and functional improvement and response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The MTUS guidelines also note that opioids, such as Percocet, may be efficacious for short-term use, but the efficacy of long-term use is limited. The MTUS guidelines state continuation of opioids is recommended if the patient has returned to work and if the patient has improved functioning and pain. The medical records do not demonstrate either return to work or improvement in function and pain with opioid use. Ongoing opioid usage, in the absence of significant functional improvement is not supported. The medical necessity of Percocet has not been established.

PRESCRIPTION FOR FENTANYL 50MCG/HR #10: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS.

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

Decision rationale: Duragesic[®] (fentanyl transdermal system) is not recommended as a first-line therapy. Duragesic is the trade name of a fentanyl transdermal therapeutic system, which releases fentanyl, a potent opioid, slowly through the skin. The Food and Drug Administration (FDA)-approved product labeling states that: Duragesic is indicated in the management of chronic pain in patients who require continuous opioid analgesia for pain that cannot be managed by other means. The medical records do not establish continued use of the patches led to clinically significant reduction in pain or improved function. The patient persistently reports severe pain levels, has not demonstrated improved function, has not returned to work, and the documented physical examination findings are minimal and unchanged. Given the lack of benefit, continued Fentanyl is not recommended under the guidelines. The guidelines note that chronic opioid use can lead to hyperalgesia. Fentanyl is an opioid analgesic with potency much higher than that of morphine. This strong opioid medication has the potential of significant side effects. The medical records do not establish non-opioid analgesics are not sufficiently appropriate to address this patient's pain complaints. The medical records do not establish the patient requires continuous opioid analgesia that cannot be managed by other means. Considering that the patient has a spinal cord stimulator implant, it is unclear why she continues potent opioids as well. The request is not supported by the guidelines, as the medical necessity has not been established.