

<b>Case Number:</b>	CM14-0121902		
<b>Date Assigned:</b>	08/06/2014	<b>Date of Injury:</b>	04/17/1997
<b>Decision Date:</b>	09/24/2014	<b>UR Denial Date:</b>	07/29/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/01/2014

### 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. Physical Medicine & Rehabilitation has a subspecialty in Interventional Spine 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 50 year old with an injury date on 4/17/97. Patient complains of shoulder, wrist, lumbar, cervical, and bilateral lower extremity pain per 7/7/14 report. The pain is described as burning, aching, tight, stiff, and constant that radiates into left leg, pain rated 9/10 per 7/7/14 report. Based on the 7/7/14 progress report provided by Dr. [REDACTED] the diagnoses are: 1. spondylosis, lumbar without myelopathy 2. Bursitis, subacromial 3. Carpal tunnel syndrome 4. Lumbar radiculopathy 5. Spondylosis, cervical without myelopathy 6. Myosis pain/fibromyosis/myalgia 7. Lumbago 8. Nerve neuralgia 9. Cervicalgia 10. Pain, shoulder 11. Insomnia with sleep apnea. Exam on 7/7/14 showed "C-spine range of motion is reduced, especially flexion at 15 degrees. Right shoulder range of motion reduced with flexion/abduction at 120 degrees. L-spine range of motion slightly reduced. Normal lower extremity neurological exam. Sensation in dermatomes is normal bilaterally." Dr. [REDACTED] is requesting Methadone 10mg #150, and 1 left lumbar transforaminal lumbar epidural. The utilization review determination being challenged is dated 7/29/14. Dr. [REDACTED] is the requesting provider, and he provided treatment reports from 12/6/13 to 7/7/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Methadone 10mg #150:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-78.

**Decision rationale:** This patient presents with shoulder, wrist, back, neck, and bilateral leg pain. The provider has asked for methadone 10mg #150 on 7/7/14. Patient has been taking methadone since 12/6/13 report. For chronic opioids use, MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. In this case, the provider indicates a decrease in pain with current medications which include Methadone, but there is no discussion of this medication's efficacy in terms of functional improvement, quality of life change, or increase in activities of daily living. Given the lack of sufficient documentation regarding chronic opiates management as required by MTUS, therefore, this request is not medically necessary.

**1 left lumbar 4 Transforaminal lumbar epidural:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Lumbar Epidural Steroid Injections (ESIs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs) Page(s): 46 OF 127.

**Decision rationale:** This patient presents with shoulder, wrist, back, neck, and bilateral leg pain. The provider has asked for 1 left lumbar transforaminal lumbar epidural on 7/7/14. The 7/7/14 report clarifies the location of requested injection as left L5. The provider states, MRI revealed of the lumbar spine revealed herniation but does not specify the location or describe the significance of the protrusion. The MRI was not provided for my review. Regarding epidural steroid injections, MTUS recommends ESIs as an option for treatment of radicular pain, "defined as pain in the dermatomal distribution with corroborative findings of radiculopathy." In this case, the patient presents with some radiating pain down the lower extremities, but there is no imaging to corroborate significant herniation or stenosis. The request for a left lumbar transforaminal lumbar epidural injection is not indicated at this time. Therefore, this request is not medically necessary.