

Case Number:	CM14-0182533		
Date Assigned:	11/07/2014	Date of Injury:	06/06/1991
Decision Date:	12/11/2014	UR Denial Date:	10/22/2014
Priority:	Standard	Application Received:	11/03/2014

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 Neurology, has a subspecialty in Neuromuscular Medicine and is licensed to practice in New Jersey. 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 67-year-old woman who sustained a work-related injury on June 6, 1991. Subsequently, she developed chronic low back pain. MRI of the lumbar spine performed on April 23, 2007 showed mild-to-moderate degenerative disc disease and spondylosis, most severe within the upper lumbar spine and mild facet osteoarthritis, most severe within the lower lumbar spine. No focal protrusion or major central or foraminal stenosis. Mild scoliosis with slight retrolisthesis with L1 relative to L2 and L2 relative to L3. On May 5, 2014, the patient underwent a left lumbar 4 and 5 transforaminal epidural injections with 50% relief. According to a progress report dated October 13, 2014, the patient complained of low back pain. She described the pain as aching, dull, sharp, shock-like sensation. The pain radiated down the left leg. The patient rated her pain as a 6/10 without medications. Treatments have included narcotics, physical therapy, and chiropractic treatment. Examination of the lumbar spine revealed abnormal range of motion at 45 degrees of true flexion, 10 degrees of extension and 15 degrees of right lateral flexion, 15 degrees of left lateral flexion, 10 degrees of right rotation, and 10 degrees of left rotation. The patient had pain with lumbar spine range of motion testing. Straight leg in raising supine: right 90 degrees and negative; left 90 degrees and negative. Sitting straight leg raise: negative bilaterally. Slump test: negative bilaterally. Patrick test: positive bilaterally. Reverse Thomas test: positive bilaterally. The patient's neurological exam was normal with reflexes, sensation, and muscle strength. The patient was diagnosed with wrist enthesopathy, lumbar radiculopathy, hip enthesopathy, herniated lumbar disc, sacroiliac joint disorder, degenerative lumbar disc, and lumbar spondylosis. The provider requested authorization for Lyrica, Percocet, and Left Lumbar L4-5 Transforaminal Epidural Steroid Injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

(1) Prescription of Lyrica 150mg, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lyrica Page(s): 20.

Decision rationale: According to MTUS guidelines, Lyrica is anti-epilepsy drug (AEDs - also referred to as anti-convulsants), which has been shown to be effective for treatment of diabetic; painful neuropathy and post-herpetic neuralgia; and has been considered as a first-line treatment for neuropathic pain. There is no clear documentation of neuropathic pain in this patient. In addition, there is no clear proven efficacy of Lyrica for shoulder, neck, back and knee pain. There is no documentation of the pain severity and justification for continuous use of Lyrica. Therefore, Lyrica 150mg, #60 is not medically necessary.

(1) Prescription of Percocet 10/325mg, #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, for chronic pain.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Criteria for use of opioids, page(s) 179.

Decision rationale: According to MTUS guidelines, ongoing use of opioids should follow specific rules:(a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy.(b) The lowest possible dose should be prescribed to improve pain and function.(c) Office: Ongoing review and documentation of pain relief, functional status,appropriate medication use, and side effects. Pain assessment should include: currentpain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework.The patient has been using opioids for long period of time without recent documentation of full control of pain and without any documentation of functional or quality of life improvement. There is no clear documentation of patient improvement in level of function, quality of life, adequate follow up for absence of side

effects and aberrant behavior with a previous use of narcotics. Therefore the prescription of Percocet 10/325mg, #90 is not medically necessary.

(1) Left Lumbar L4-5 Transforaminal Epidural Steroid Injection (TFE): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

Decision rationale: According to MTUS guidelines, epidural steroid injection is optional for radicular pain to avoid surgery. It may offer short term benefit however there is no significant long term benefit or reduction for the need of surgery. Furthermore, the patient file does not document that the patient is candidate for surgery. In addition, and although the patient have some evidence of benefit from a previous epidural injection, there is no evidence that the improvement lasted more than 6-8 weeks. There is no documentation of reduction of pain medications. Therefore, Left Lumbar L4-5 Transforaminal Epidural Steroid Injection is not medically necessary.