MAXIMUS Federal Services

Case Number:	CM14-0023505		
Date Assigned:	06/11/2014	Date of Injury:	02/11/2008
Decision Date:	07/15/2014	UR Denial Date:	02/11/2014
Priority:	Standard	Application Received:	02/25/2014

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 Family Medicine and is licensed to practice in Arizona. 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 52 year old female with a date of injury on 2/11/2008. Diagnoses include lumbar disc disease with radiculitis, reflex sympathetic dystrophy, and knee pain. Subjective complaints are of low back with radiation to the bilateral legs and hips with tingling, numbness and weakness. Pain is rated as 8/10 mostly concentrated in the low back. Physical exam shows antalgic gait, and decreased lumbar range of motion with pain. There was decreased sensation along bilateral L5-S1 dermatomes. Leg raise test was positive. Medications for related symptoms include Percocet 10/325 six times per day, and Ativan 0.5mg one tablet at night, Lunesta, Cymbalta, and Soma. Other medications include Dicyclomine, Miralax, Nasonex, Astelin, Xyzal, Xoponex, Proventil, Singulair, Spiriva, and Bystolic. The patient has had prior lumbar transformational epidural steroid injections on 5/23/12 and 9/25/13 with more than 50% pain relief several months. Prior electrodiagnostic studies showed left acute L5-S1 radiculopathy and acute right S1 radiculopathy. Lumbar MRI from 7/22/13 showed degenerative disc disease at L4-S1, small disc protrusion at L4-L5 and facet disease at L4-S1. Submitted documentation indicates that opioid medication helps reduce her pain, and that urine drug screening has been consistent.

IMR ISSUES, DECISIONS AND RATIONALES

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

LUMBAR TRANSFORAMINAL EPIDURAL STEROID INJECTION BILATERAL L4-L5, TWO (2) LEVELS EACH SIDE QTY: 2.00: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection Page(s): 46.

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

Decision rationale: The CA MTUS notes that the purpose of epidural steroid injection (ESI) is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. For therapeutic injections, repeat blocks should be based on continued objective pain relief and functional improvement, including at least 50% improvement for 6 to 8 weeks. The American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months. This patient had a previous injection that did demonstrate pain relief and functional improvement for up to 2-3 months. Guidelines indicate that repeat injections should only be given if evidence is present of lasting effects for 6-8 weeks. For this patient, documentation does support lasting relief from prior injections; therefore the medical necessity of a repeat ESI is established.

PERCOCET 10/325MG #180: Overturned

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

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

Decision rationale: The Chronic Pain Guidelines has specific recommendations for the ongoing management of opioid therapy. Clear evidence should be presented about the degree of analgesia, level of activity of daily living, adverse side effects, or aberrant drug taking behavior. For this patient, clear documentation shows stability on medication, increased functional ability, and no adverse side effects. Furthermore, documentation is present of MTUS opioid compliance guidelines, including urine drug screening, risk assessment, and ongoing efficacy of medication. Therefore, the use of this medication is consistent with guidelines and is medically necessary for this patient.

ATIVAN 0.5MG #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: The CA MTUS guidelines do not recommend anxiolytics as first line therapy for stress-related conditions as they can lead to dependence and do not alter stressors or the individual's coping mechanisms. Benzodiazepines in particular are not recommended for long-term use because long-term efficacy is unproven. Most guidelines limit use to 4 weeks, due to dependence and tolerance that can occur within weeks. For this patient, Ativan has been utilized chronically for sleep and stress, which exceeds guideline recommendations. Furthermore, submitted documentation does not indicate prior psychological evaluation or rationale for ongoing therapy with benzodiazepines. Due to these reasons, the medical necessity of Ativan is not established.