

<b>Case Number:</b>	CM14-0056265		
<b>Date Assigned:</b>	07/09/2014	<b>Date of Injury:</b>	04/25/1990
<b>Decision Date:</b>	11/07/2014	<b>UR Denial Date:</b>	04/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/25/2014

### 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 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 62 year old female with an injury date of 04/25/90. The 04/03/14 report states that the patient presents with continued lower back pain that extends to the left hip and leg rated 8/10. The patient mostly ambulates with a wheelchair and walker. Reports do not state if the patient is working. Examination of the lumbar spine reveals marked tenderness over facet joints and lumbar spinous processes. Left and right paralumbar show tenderness. The left knee has pain on movement with tenderness over patella, slightly effused. There is AL joint line tenderness and AM joint line tenderness; and lower leg redness and swelling with ankle swelling. The patient's diagnoses include: Lumbago, low back pain, SI joint dysfunction, abdomen pain unspecified, and "Encntr long-RX use NEC". Current medication is listed as Avinza, Neurontin, Xanax, Trazodone, Toradol, Soma, Lidoderm, and Dilaudid. The utilization review being challenged is dated 04/10/14. Reports were provided from 09/09/13 to 04/03/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Avinza ER 120mg #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
CRITERIA FOR USE OF OPIOIDS Page(s): 76-78, 88-89.

**Decision rationale:** The patient presents with continued lower back pain extending to the left hip and leg rated 8/10. The treater requests for Avinza ER (Morphine Sulfate) 120 mg #30. The reports provided indicate the patient has been taking this medication since before 09/09/13. 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." Two treatment reports were provided dated 09/09/13 and 04/03/14. Pain decreased from 9/10 to 8/10 with medications. On 04/03/14 the treater states the patient's current medication schedule reduces the pain to a tolerable level. The treater states the patient mostly uses a wheel chair for ambulation and can perform self-care. No other specific ADL's are mentioned to show a significant change with use of this medication. The treater notes no aberrant behavior; however, the reports do not document discussion of adverse side effects. Urine toxicology reports were provided for 01/14/14 showing the presence of Hydromorphone and on 04/03/14 showing positive for opioids. There is no documentation of outcome measures. In this case, there is not sufficient documentation to support long-term opioid use as required by MTUS. Therefore, this request is not medically necessary.

**Dilaudid 4mg #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
CRITERIA FOR USE OF OPIOIDS Page(s): 76-78, 88-89.

**Decision rationale:** The patient presents with continued lower back pain extending to the left hip and leg rated 8/10. The treater requests for Dilaudid (Hydromorphone and opioid) 4 mg #20. The reports provided indicate the patient has been taking this medication since before 09/09/13. 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." Two treatment reports were provided dated 09/09/13 and 04/03/14. Pain decreased from 9/10 to 8/10 with medications. On 04/03/14 the treater states the patient's current medication schedule reduces the pain to a tolerable level. The treater states the patient mostly uses a wheel chair for ambulation and can perform self-care. No other specific ADL's are mentioned to show a significant change with use of this medication. The treater notes no aberrant behavior; however, the reports do not document discussion of adverse side effects. Urine toxicology reports were provided for 01/14/14 showing the presence of Hydromorphone and on 04/03/14 showing present for opioids. There is no documentation of

outcome measures. A change from 9/10 to 8/10 does not appear significant enough to warrant continued use of long term opiates. In this case, there is not sufficient documentation to support long-term opioid use as required by MTUS. Therefore, this request is not medically necessary.

**Physical Therapy 2 x 6 for total of 12 visits:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 98-99.

**Decision rationale:** The patient presents with continued lower back pain extending to the left hip and leg rated 8/10. The treater requests for physical therapy 2 x 6 for total of 12 visits. There is no documentation in the reports provided that indicated that the patient is within a post-surgical treatment period. MTUS Physical Treatment on pages 98, 99, states that for Myalgia and myositis 9-10 visits are recommended over 8 weeks. In addition, for Neuralgia, neuritis and radiculitis 8-10 visits are recommended. Only two treatment reports were provided dated 04/03/14 and 09/09/13. The treater does not discuss why physical therapy is required for the patient at this time. There is no documentation showing a flare up or change in function for the patient. Furthermore, the 12 visits requested exceed the MTUS guidelines. Therefore, this request is not medically necessary.

**Left-sided sacroiliac joint injection, pirlformis injection, trochanteric bursa injection:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip & pelvis chapter; Sacroiliac joint blocks

**Decision rationale:** The patient presents with continued lower back pain extending to the left hip and leg rated 8/10. The treater requests for left side sacroiliac joint injection, piriformis, injection, and trochanteric bursa injection. Official Disability Guidelines (ODG) state SI joint injections are recommended as an option if failed at least 4-6 weeks of aggressive conservative therapy. ODG further states that, "The history and physical should suggest the diagnosis (with documentation of at least 3 positive exam findings as listed..." "\*Diagnosis: \*Specific tests for motion palpation and pain provocation have been described for SI joint dysfunction: Cranial Shear Test; Extension Test; Flamingo Test; Fortin Finger Test; Gaenslen's Test; Gillet's Test (One Legged-Stork Test); Patrick's Test (FABER); Pelvic Compression Test; Pelvic Distraction Test; Pelvic Rock Test; Resisted Abduction Test (REAB); Sacroiliac Shear Test; Standing Flexion Test; Seated Flexion Test; and Thigh Thrust Test (POSH)." The treater states on 04/03/14 that the patient received SI joint triple blocks in the past and they have helped tremendously. No operative reports or follow ups of this procedure were among the reports

provided, and the dates are not known. In this case, examination of the patient does not reveal positive exam findings as required by ODG guidelines above. Therefore, this request is not medically necessary.