

Case Number:	CM14-0187928		
Date Assigned:	11/18/2014	Date of Injury:	12/08/2010
Decision Date:	01/06/2015	UR Denial Date:	10/28/2014
Priority:	Standard	Application Received:	11/11/2014

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 Occupational Medicine 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 49-year-old female who has submitted a claim for postlumbar laminectomy syndrome, lumbar radiculopathy and lumbar degenerative disc disease associated with an industrial injury date of 12/8/2010. Medical records from 2012 to 2014 were reviewed. The patient complained of low back pain radiating to bilateral lower extremities rated 10/10 in severity and slightly relieved to 9/10 with medications. Her activity level had decreased. No side effects were reported from medications. She reported that Duragesic 25mcg patch only provided her minimal pain relief. She tried using two patches of 25mcg and reported decreased pain severity to 3/10 and allowed her to increase her activity level. This action also minimized her intake of Norco. Physical examination showed limited lumbar motion, spasm and tenderness over paralumbar muscles, tight muscle band, positive straight leg raise test on the right, weak right extensor hallucis longus and right ankle dorsiflexors / plantarflexors rated 5-/5, and diminished sensation over the right foot. Urine drug screen from 8/27/2014 showed consistent result with prescription medications. The MRI of the lumbar spine, dated 3/28/2011, demonstrated multilevel disc protrusion with mild spinal canal stenosis. A repeat lumbar MRI from 2/28/2012 showed increasing disc size herniation with right S1 nerve root effacement and mild spinal stenosis. Treatment to date has included lumbar fusion on 2013, lumbar microdiscectomy on 2012, L5 and S1 TFESI on the right on 5/20/2011 (resulting to worsening pain), physical therapy, Gabapentin (since 2013), Docusate, Senokot, Duragesic patch (since 2011), Norco (since 2011), and Flexeril. The utilization review from 10/28/2014 denied the request for MRI (magnetic resonance imaging) of the lumbar spine with contrast because of no specific nerve compromise on physical examination; denied caudal epidural with catheter because of insufficient subjective and objective findings for unequivocal radiculopathy; denied Duragesic 75mcg/hr patch because no pain relief noted from its use; denied Norco 10/325mg

#120 because of no supporting evidence of objective functional benefit with medication use; and denied Gabapentin because of no evidence of neuropathic pain to warrant such.

IMR ISSUES, DECISIONS AND RATIONALES

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

One MRI (magnetic resonance imaging) of the lumbar spine with contrast: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Chapter 12: Low Back Complaint (2007), page 53, Indications for imaging - magnetic resonance imaging

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Section, MRI

Decision rationale: As stated on pages 303-304 of the ACOEM Practice Guidelines referenced by CA MTUS, imaging of the lumbar spine is recommended in patients with red flag diagnoses where plain film radiographs are negative; unequivocal objective findings that identify specific nerve compromise, failure to respond to treatment, and consideration for surgery. In addition, Official Disability Guidelines recommends MRI for the lumbar spine for uncomplicated low back pain, with radiculopathy, after at least 1 month of conservative therapy, sooner if severe, or progressive neurologic deficit. In this case, the patient is status post lumbar fusion in 2013, lumbar microdiscectomy in 2012, L5 and S1 TFESI on the right on 5/20/2011. However, she recently had worsening low back pain radiating to bilateral lower extremities rated 10/10 in severity. Her activity level had decreased. Physical examination showed limited lumbar motion, spasm and tenderness over paralumbar muscles, tight muscle band, positive straight leg raise test on the right, weak right extensor hallucis longus and right ankle dorsiflexors / plantarflexors rated 5-/5, and diminished sensation over the right foot. The MRI of the lumbar spine, dated 3/28/2011, demonstrated multilevel disc protrusion with mild spinal canal stenosis. A repeat lumbar MRI from 2/28/2012 showed increasing disc size herniation with right S1 nerve root effacement and mild spinal stenosis. Given the worsening of clinical manifestations despite extensive treatment received, the medical necessity for repeat imaging has been established. Therefore, the request for MRI (magnetic resonance imaging) of the lumbar spine with contrast is medically necessary.

One Caudal Epidural With Catheter: 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 Injection Page(s): 46.

Decision rationale: As stated on page 46 of CA MTUS Chronic Pain Medical Treatment Guidelines, Epidural Steroid Injection (ESI) is indicated among patients with radicular pain that has been unresponsive to initial conservative treatment. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks. In this case, the patient complained of low back pain radiating to bilateral lower extremities rated 10/10 in severity and slightly relieved to 9/10 with medications. Her activity level had decreased. Physical examination showed limited lumbar motion, spasm and tenderness over paralumbar muscles, tight muscle band, positive straight leg raise test on the right, weak right extensor hallucis longus and right ankle dorsiflexors / plantarflexors rated 5-/5, and diminished sensation over the right foot. The MRI of the lumbar spine, dated 3/28/2011, demonstrated multilevel disc protrusion with mild spinal canal stenosis. A repeat lumbar MRI from 2/28/2012 showed increasing disc size herniation with right S1 nerve root effacement and mild spinal stenosis. The patient is status post lumbar fusion on 2013 and lumbar microdiscectomy on 2012. However, she reported worsening of symptoms proceeding L5 and S1 TFESI on the right on 5/20/2011. Guideline criteria for repeat ESI are not met. Moreover, the patient is currently pending for a repeat MRI of the lumbar spine. Therefore, the request for One Caudal Epidural With Catheter is not medically necessary.

One prescription of Duragesic 75mcg/hr patch: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic (fentanyl transdermal system); Opioids, criteria for use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Duragesic; Opioids; Fentanyl (transdermal) Page(s): 44; 78; 93.

Decision rationale: Page 44 of CA MTUS Chronic Pain Medical Treatment Guidelines states that "Duragesic (Fentanyl transdermal system) is not recommended as a first-line therapy. Furthermore, page 93 also states that Duragesic is indicated for management of persistent chronic pain, which is moderate to severe requiring continuous, around-the-clock opioid therapy that cannot be managed by other means (e.g., NSAIDs). , There are 4 A's for ongoing monitoring of opioid use: pain relief, side effects, physical and psychosocial functioning and the occurrence of any potentially aberrant drug-related behaviors. In this case, the patient was prescribed Duragesic patch since 2011. She reported that Duragesic 25mcg patch only provided her minimal pain relief. She tried using two patches of 25mcg and reported decreased pain severity to 3/10 and allowed her to increase her activity level. This action also minimized her intake of Norco. The medical necessity for prescribing Duragesic 75mcg has been established. However, the present request as submitted failed to specify quantity to be dispensed. The request is incomplete; therefore, the request for Duragesic 75mcg/hr patch is not medically necessary.

One prescription of Norco 10/325mg #120: Upheld

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

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

Decision rationale: As stated on page 78 of CA MTUS Chronic Pain Medical Treatment Guidelines, there are 4 A's for ongoing monitoring of opioid use: pain relief, side effects, physical and psychosocial functioning and the occurrence of any potentially aberrant drug-related behaviors. The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. In this case, the patient has been on Norco since 2011. No side effects were reported from medications. Urine drug screen from 8/27/2014 likewise showed consistent result with prescription medications. However, the patient complained of low back pain radiating to bilateral lower extremities rated 10/10 in severity and slightly relieved to 9/10 with medications. Her activity level had also decreased. There is no evidence of significant pain relief and functional improvement derived from Norco. Therefore, the request for Norco 10/325mg #120 is not medically necessary.

One prescription of Gabapentin: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drugs Page(s): 16-17.

Decision rationale: As stated on pages 16-17 of CA MTUS Chronic Pain Medical Treatment Guidelines, antidepressants, such as pregabalin and gabapentin, are recommended as a first line option for neuropathic pain, i.e., painful polyneuropathy. In this case, the patient has been on gabapentin as early as 2013. The patient's manifestation of chronic low back pain radiating to bilateral lower extremities associated with numbness is consistent with neuropathic pain. However, there is no documentation concerning pain relief and functional improvement with gabapentin use. The request likewise failed to specify dosage, frequency of intake, and quantity to be dispensed. Therefore, the request for Gabapentin is not medically necessary.