

Case Number:	CM14-0065571		
Date Assigned:	07/11/2014	Date of Injury:	04/03/2012
Decision Date:	07/01/2015	UR Denial Date:	04/18/2014
Priority:	Standard	Application Received:	05/08/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials: State(s) of Licensure: Florida
Certification(s)/Specialty: Neurology, Pain Management

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 injured worker is a 31 year old male, who sustained an industrial injury on 04/03/2012. He has reported injury to the low back. The diagnoses have included lumbosacral spondylosis; bilateral lumbar facet syndrome at L4-L5 and L5-S1 levels; left lumbosacral radiculitis with neuroclaudication; and status post anterior/posterior L3-4 fusion. Treatment to date has included medications, diagnostics, epidural injections, chiropractic treatments, physical therapy, and surgical intervention. Medications have included Roxicodone, Aciphex, Celebrex, and Flexeril. A progress note from the treating physician, dated 04/08/2014, documented a follow-up visit with the injured worker. The injured worker reported intractable low back pain and bilateral hip pain, left worse than right; pain is associated with stiffness and muscle spasms of the lumbar spine area; pain radiates into the left lower extremity; and pain is rated 6-7/10 on the visual analog scale. Objective findings included lumbar spine tenderness from L3 to L5 level bilaterally; bilateral lumbar facet tenderness at L3-L4, L4-L5 and L5-S1 level; left lower extremity weakness; and lumbar spine range of motion is very limited. The treatment plan has included the request for one (1) left lumbar transforaminal epidural steroid injection at L3-L4 and L4-L5 levels under fluoroscopy; Roxicodone 30mg #90; Flexeril 5mg #28; and Ambien 5mg #15.

IMR ISSUES, DECISIONS AND RATIONALES

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

One (1) left lumbar transforaminal epidural injection at L3-L4 and L4-L5 levels under fluoroscopy: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation official disability guidelines - low back, ESI.

Decision rationale: The medical records provided for review do document physical exam findings consistent with radiculopathy in association with plan for epidural steroid injection but does not document corroboration by imaging. There is also no specified functional gain or pain improvement in terms of duration or degree in relation to first ESI performed in support of second ESI. ODG guidelines support ESI when (1) Radiculopathy (due to herniated nucleus pulposus, but not spinal stenosis) must be documented. Objective findings on examination need to be present. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing. (2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). (3) Injections should be performed using fluoroscopy (live x-ray) and injection of contrast for guidance. As such, the medical records do not support the use of ESI congruent with ODG guidelines.

Roxicodone 30mg #90: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation official disability guidelines - pain, opioids.

Decision rationale: ODG guidelines support opioids with: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; 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 The medical records report chronic pain but does not document ongoing opioid risk mitigation tool use in support of chronic therapy congruent with ODG guidelines. As such, chronic opioids are not supported.

Flexeril 5mg #28: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Flexeril (Cyclobenzaprine).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines flexeril
Page(s): 41.

Decision rationale: MTUS guidelines support the use of Flexeril for short-term therapy for treatment of muscle spasms. The medical records provided for review does not indicate ongoing muscle spasm or spasticity. As such, the medical records do not demonstrate findings on exam in support of muscle relaxant or demonstrate intent to treat with short-term therapy in congruence with guidelines.

Ambien 5mg #15: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic) Zolpidem.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation official disability guidelines - pain, zolpidem.

Decision rationale: The medical records provided for review do not indicate significant sleep interference. ODG guidelines support short-term use of sleep agent such as zolpidem for 4 to 6 weeks if there is demonstrated failure of at least 6 months of sleep hygiene program. Zolpidem is a prescription short-acting nonbenzodiazepine hypnotic, which is approved for the short-term (usually two to six weeks) treatment of insomnia. Proper sleep hygiene is critical to the individual with chronic pain and often is hard to obtain. As such, zolpidem is not supported for the claimant.