

Case Number:	CM15-0003343		
Date Assigned:	01/14/2015	Date of Injury:	07/01/2011
Decision Date:	03/13/2015	UR Denial Date:	12/23/2014
Priority:	Standard	Application Received:	01/07/2015

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 59 year old female who sustained an industrial injury on 12/23/2014. Diagnoses include lumbalgia and acute musculoskeletal injury. She is status post discectomy L4-5 in April of 2012. The treating provided is requesting a Magnetic Resonance Imaging of the lumbar spine, a computed tomography guided epidural steroid injection, and Vicodin 7.5/325mg 1-2 tablets every 4 hours # 120. A physician progress note documents the injured worker has progressive pain in the lower back, bilateral lower extremity radiculopathy, right greater than left, currently pain is rated 7 out of 10. She has had transient relief with surgery and epidural steroid injection, with recurrent pain.

On 12/23/2014 Utilization Review modified a request for Vicodin 7.5/325mg 1-2 tablets every 4 hours, # 120 to Vicodin 7.5/325mg to # 60, citing California Medical Treatment Utilization Schedule (MTUS)-Chronic Pain Medical Treatment Guidelines. Utilization Review non-certified the request for Magnetic Resonance Imaging of the lumbar spine citing California Medical Treatment Utilization Schedule (MTUS), American College of Occupational and Environmental Medicine(ACOEM), and Official Disability Guidelines. Utilization Review non-certified the request for a computed tomography guided epidural steroid injection, citing California Medical Treatment Utilization Schedule (MTUS)-Chronic Pain Medical Treatment Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Vicodin 7.5mg 325mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Opioids, specific drug list for Hydrocodone/Acetaminophen Page(s):.

Decision rationale: According to the 12/23/14 Utilization Review letter, the Vicodin 7.5mg, 325mg, #120 requested on the 11/15/14 medical report was denied because the patient was on Vicodin 5/325mg and has history of medication misuse. According to the 11/15/14 medical report, the patient is a 59 year-old female a 7/1/11 date of injury. She presents with 7/10 pain in the low back, with bilateral lower extremity radiculopathy. She had transient relief from the discectomy at L4/5 in 4/2012 and has recurrent, progressive pain. The diagnoses include acute and chronic lumbar pain; bilateral lower extremity radiculopathy; degenerative disc disease; morbid obesity; "completed procedures: ESI are effective". The plan included increasing Vicodin 5/325mg to Vicodin 7.5/325mg 1-2 tablets every 4 hours for pain #120. There was no rationale provided for the increase. MTUS Chronic Pain Medical Treatment Guidelines, pg 90 Opioids, specific drug list for Hydrocodone/Acetaminophen, states: "Hydrocodone has a recommended maximum dose of 60mg/24 hours". The request for Vicodin 7.5/325mg at 2 tablets every 4 hours will exceed the MTUS recommendations. MTUS Chronic Pain Medical Treatment Guidelines, page 88-89 for "Opioids, long-term assessment CRITERIA FOR USE OF OPIOIDS Long-term Users of Opioids [6-months or more]" provides the criteria. "Document pain and functional improvement and compare to baseline. 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. Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." "There is no reporting on efficacy of the medications, the documentation does not support a satisfactory response. There is no mention of improved pain, or improved function or improved quality of life with the use of Vicodin. MTUS does not recommend continuing treatment if there is not a satisfactory response. Based on the available records, the request for Vicodin 7.5mg, 325mg, #120, IS NOT medically necessary.

CT-guided ESI: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ESI Page(s): 46-47.

Decision rationale: According to the 12/23/14 Utilization Review letter, the CT-guided ESI requested on the 11/15/14 medical report was denied because there was insufficient improvement with the prior ESI. According to the 11/15/14 medical report, the patient is a 59 year-old female a 7/1/11 date of injury. She presents with 7/10 pain in the low back, with bilateral lower

extremity radiculopathy. She had transient relief from the discectomy at L4/5 in 4/2012 and has recurrent, progressive pain. The diagnoses include acute and chronic lumbar pain; bilateral lower extremity radiculopathy; degenerative disc disease; morbid obesity; "completed procedures: ESI are effective." The plan included "CT-guided ESI". The record review on the 10/12/14 AME report states the patient had a 3rd bilateral L5/S1 TFESI on 2/8/12, but on 2/18/12 there was only brief improvement with the ESI. The 10/12/14 AME report states there was a lumbar MRI on 8/15/12 showing the surgical changes, but no recurrent disc herniation. There were no imaging or electrodiagnostic reports provided with this review, and the requesting physician did not specify the level for the requested ESI. MTUS Chronic Pain Treatment Guidelines, section on "Epidural steroid injections [ESIs]" page 46 states these are "Recommended as an option for treatment of radicular pain [defined as pain in dermatomal distribution with corroborative findings of radiculopathy]." The MTUS Criteria for the use of Epidural steroid injections states: "Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing." And "In the therapeutic phase, 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." The provided medical records did not show MRI or electrodiagnostic studies to support a diagnosis of radiculopathy, as required under the MTUS guidelines. The prior epidural injections were in the lumbar region and did not provide pain relief for 6-8 weeks, to support additional injections. The request is not in accordance with MTUS guidelines. The request for "CT-guided ESI" at an unknown level IS NOT medically necessary.

MRI L/S: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305. Decision based on Non-MTUS Citation Low Back Chapter, MRIs

Decision rationale: According to the 12/23/14 Utilization Review letter, the MRI L/S requested on the 11/15/14 medical report was denied because there was no progressive neurologic deficits documented. According to the 11/15/14 medical report, the patient is a 59 year-old female a 7/1/11 date of injury. She presents with 7/10 pain in the low back, with bilateral lower extremity radiculopathy. She had transient relief from the discectomy at L4/5 in 4/2012 and has recurrent, progressive pain. The diagnoses include acute and chronic lumbar pain; bilateral lower extremity radiculopathy; degenerative disc disease; morbid obesity; "Completed procedures: ESI are effective." The plan included an updated MRI of the lumbar spine. MTUS/ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12 "Low Back Complaints" under Special Studies and Diagnostic and Treatment Considerations, pg 303-305 states "Unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option." MTUS/ACOEM did not specifically discuss repeat MRIs, so ODG guidelines were consulted. ODG Low Back Chapter for MRIs states Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology eg, tumor, infection, fracture, neurocompression, recurrent disc

herniation. The available records did not provide a rationale for the repeat MRI other than the last one was 2-years ago. There was no mention of any progressive neurologic deficits or findings of significant pathology that would warrant a repeat MRI. Based on the provided records, the request for "MRI L/S" IS NOT medically necessary.