

Case Number:	CM15-0006103		
Date Assigned:	01/26/2015	Date of Injury:	06/19/2013
Decision Date:	03/25/2015	UR Denial Date:	12/10/2014
Priority:	Standard	Application Received:	01/13/2015

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: Colorado

Certification(s)/Specialty: Family Practice

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 53 year old male, who sustained an industrial injury on 06/19/2013. He has reported subsequent low back pain radiating to the lower extremities and was diagnosed with lumbar radiculopathy, lumbar spondylosis, degenerative disc disease and sprain/strain of the lumbar spine. Treatment to date has included oral pain medication, formal physical therapy and a home exercise program, chiropractic therapy and acupuncture. In a progress note dated 11/24/2014, the injured worker complains of mid lumbosacral pain with radiation to the right lateral calf. The pain was rated as 5/10 and was constant. The injured worker was noted to have a severe 3-4 hour episode of pain every two months that was so painful that he could not get up from bed. Objective examination findings were notable for tenderness on the supraspinous ligament, bilateral erector spinae and bilaterally adjacent to the spinous processes in the low lumbar spine, extreme limitation in flexion in the lumbar spine and positive supine straight leg raise bilaterally. A request was made for a lumbar epidural steroid injection on the right at L4-L5 and L5-S1 for abrupt worsening of right lower extremity pain and a request was made for Percocet for pain. On 12/10/2014, Utilization Review non-certified a request for transforaminal steroid injection of L4-L5 and L5-S1 noting that the physical examination showed no clear focal findings of radiculopathy and modified a request for Percocet from 10/325 mg #120 to 10/325 mg #120 for one month noting that the records lacked clear documentation of an assessment profile, attempt at weaning/tapering and an updated and signed pain contract. MTUS, ACOEM and ODG guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Treatments and Interventions Page(s): 79-80, 85, 88-89.

Decision rationale: The Guidelines establish criteria for use of opioids, including long term use (6 months of more). When managing patients using long term opioids, the following should be addressed: Re-assess the diagnosis and review previous treatments and whether or not they were helpful. When re-assessing, pain levels and improvement in function should be documented. (Information from sources other than patient can also be considered.) Pain levels should be documented every visit. Function should be evaluated every 6 months using a validated tool. Adverse effects, including hyperalgesia, should also be addressed each visit. Patient's motivation and attitudes about pain / work / interpersonal relationships can be examined to determine if patient requires psychological evaluation as well. Aberrant / addictive behavior should be addressed if present. Do not decrease dose if effective. Medication for breakthrough pain may be helpful in limiting overall medication. Follow up evaluations are recommended every 1-6 months. To summarize, the 4A's of Drug Monitoring (analgesia, activities of daily living, adverse side effects, and aberrant drug-taking Behaviors) have been established. 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. (Passik, 2000) Several circumstances need to be considered when determining to discontinue opioids: 1) Verify patient has not had failure to improve because of inappropriate dosing or under-dosing of opioids 2) Consider possible reasons for immediate discontinuation including diversion, prescription forgery, illicit drug use, suicide attempt, arrest related to opioids, and aggressive or threatening behavior in clinic. Weaning from the medication over 30 day period, under direct medical supervision, is recommended unless a reason for immediate discontinuation exists. If a medication contract is in place, some physicians will allow one infraction without immediate discontinuation, but the contract and clinic policy should be reviewed with patient and consequences of further violations made clear to patient. 3) Consider discontinuation if there has been no improvement in overall function, or a decrease in function. 4) Patient has evidence of unacceptable side effects. 5) Patient's pain has resolved. 6) Patient exhibits serious non-adherence and misuse (including urine drug testing negative for prescribed substances on 2 occasions). Per the Guidelines, Chelminski defines serious substance misuse as meeting any of the following criteria: (a) cocaine or amphetamines on urine toxicology screen (positive cannabinoid was not considered serious substance abuse); (b) procurement of opioids from more than one provider on a regular basis; (c) diversion of opioids; (d) urine toxicology screen negative for prescribed drugs on at least two occasions (an indicator of possible diversion); & (e) urine toxicology screen positive on at least two occasions for opioids not routinely prescribed. (Chelminski, 2005) 7) Patient requests discontinuing opioids. 8) Consider verifying that patient is in consultation with physician specializing in addiction to consider detoxification if patient continues to violate the medication

contract or shows other signs of abuse / addiction. 9) Document the basis for decision to discontinue opioids. Likewise, when making the decision to continue opioids long term, consider the following: Has patient returned to work Has patient had improved function and decreased pain with the opioids For the patient of concern, the record is unclear as to patient improvement with opioids, including Percocet. The treating physician notes and Agreed Medical Examination (AME) notes have conflicting information from the patient about his medications: The AME documents that patient takes only Ibuprofen for pain as of 10/24/2014, but the Pain Management notes 4 days later indicate that patient has already been taking Naprosyn, Norco, and Cyclobenzaprine for unspecified time. (Urine drug screen 10/28/2014 was Positive for Hydrocodone, though patient had indicated he had not been taking that. Not clear if this would be consistent result then.) Furthermore, one treating physician note indicates Percocet caused Gastritis, but it was restarted anyway when Norco no longer effective. Per the records, Patient reported 11/3/2014 that he, on his own, increased the Norco to 6-7 tablets per day for pain flare up without relief, so Percocet was ordered, and follow up note 11/11/2014 indicates patient taking Percocet, with no objective indication of improvement in pain or function. The treating physician notes 11/18/2014 indicate pain 3-6/10, but it is unclear if this is an improvement, and the ADL's checklist completed at that visit does not specify with or without medications. Possible leg rash due to Percocet is mentioned in the notes on this date, but Percocet not discontinued. The notes from the Pain Management clinic then 11/24/2014 indicate patient still taking Norco, not Percocet. Given the lack of documentation of consistent urine drug screens, the lack of clear improvement in pain and/or function, and the inconsistent documentation of use of Norco vs. Percocet and possible side effects, the Percocet is not medically necessary.

R, L4-5, L5-S1 Transforaminal Epidural Steroid Injections: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs) Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Regarding Epidural Steroid Injections (ESIs), Therapeutic, and Criteria for the Use of ESIs

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Treatments and Interventions Page(s): 46.

Decision rationale: Per the MTUS, epidural steroid injections are recommended as an option for treatment of radicular pain. Current guidelines indicate no more than 2 epidural steroid injections are generally needed to achieve some relief of lumbosacral pain, and no evidence suggests relief is lasting. If initial epidural steroid injection does not provide at least 50% reduction in pain as well as some improvement in function, then additional injections are not indicated. Because pain relief is short term and no long term effects on function have been identified, epidural steroid injections are recommended as part of a program including other therapies such as exercise program. There is insufficient evidence to recommend cervical epidural steroid injections to treat cervical radicular pain. Per MTUS Guidelines, the following criteria should be used to determine which patient may benefit from epidural steroid injection: 1) Radiculopathy must be documented by physical examination and 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) for guidance.4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections.5) No more than two nerve root levels should be injected using transforaminal blocks.6) No more than one interlaminar level should be injected at one session.7) 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, with a general recommendation of no more than 4 blocks per region per year. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007)8) Current research does not support a series-of-three injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections. For the patient of concern, the history includes radicular symptoms from 10/24/2014 through at least 11/11/2014, and physical findings on examination 11/11/2014 indicate radiculopathy. However, there is no corresponding MRI or electrodiagnostic studies to support radiculopathy as the diagnosis. Patient has had multiple therapies in the past without relief, but most recently has been noted to have stopped all exercise including home exercise program, so the epidural steroid injections would not be part of a more comprehensive rehabilitation program. The request for right L4-L5, L5-S1 transforaminal epidural steroid injections is not deemed medically necessary.