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| Case Number: | CM15-0147264 | | |
| Date Assigned: | 08/03/2015 | Date of Injury: | 09/11/2011 |
| Decision Date: | 09/18/2015 | UR Denial Date: | 06/26/2015 |
| Priority: | Standard | Application Received: | 07/29/2015 |

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, 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:

This 41-year-old female sustained an industrial injury to the low back on 9-11-11. Previous treatment included physical therapy, epidural steroid injections and medications. The injured worker underwent lumbar transforaminal steroid injection at L4-5 on 6-11-13 and 8-27-13. The injured worker reported initial 100% reduction of pain for 3 days. In a PR-2 dated 12-11-14, the injured worker complained of pain to the low back rated 8 out of 10 on the visual analog scale without medications and 6 out of 10 with medications. The injured worker described functional limitations including avoiding going to work, socializing with friends, performing household chores, participating in recreation, driving, doing yard work or shopping due to pain. The injured worker was prescribed Hydrocodone 5/300mg, Diclofenac XR, Gabapentin and Cymbalta. In a progress note dated 6-23-15, the injured worker complained of pain 9 out of 10 without medications and 6 out of 10 with medications. Functional limitations due to pain were unchanged. Physical exam was remarkable for lumbar spine with decreased range of motion, tenderness to palpation to the left sciatic notch and over the bilateral lumbar paraspinal musculature with spasms, positive left femoral stretch test, 4 out of 5 left ankle strength and improved sensation at the L4 and L5 distribution. Current diagnoses included enthesopathy hip region and displacement of lumbar intervertebral disc without myelopathy. The treatment plan included requesting authorization for an orthopedic consultation, a lumbar epidural steroid injection at L4-5 and medications (Hydrocodone 10/325 mg, Diclofenac R and Gabapentin).

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar epidural steroid injection L4-L5: 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 Page(s): 46.

Decision rationale: Regarding the request for epidural steroid injection, Chronic Pain Medical Treatment Guidelines state that epidural injections are recommended as an option for treatment of radicular pain, defined as pain in dermatomal distribution with corroborative findings of radiculopathy, and failure of conservative treatment. Regarding repeat epidural injections, guidelines state that 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. Within the documentation available for review, there is no indication of at least 50% pain relief with associated reduction of medication use for 6 to 8 weeks as well as functional improvement from previous epidural injections. Furthermore, there are no current clinical and imaging and/or electro diagnostic studies corroborating active radiculopathy. As such, the currently requested epidural steroid injection is not medically necessary.

Hydrocodone 10/325mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): s 44, 47, 75-79, and 120.

Decision rationale: Regarding the request for hydrocodone, California Pain Medical Treatment Guidelines state that this is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is no indication that the medication is improving the patient's function (in terms of specific examples of functional improvement), no documentation regarding side effects, and no discussion regarding aberrant use. As such, there is no clear indication for ongoing use of the medication. Opioids should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In light of the above issues, the currently requested hydrocodone is not medically necessary.

Diclofenac XR 100mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): s 67-72.

Decision rationale: Regarding the request for diclofenac XR, Chronic Pain Medical Treatment Guidelines state that NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Within the documentation available for review, there is no indication that the medication is providing any specific objective functional improvement. In the absence of such documentation, the currently requested diclofenac XR is not medically necessary.

Gabapentin 600mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): s 16-21.

Decision rationale: Regarding request for Gabapentin (Neurontin), Chronic Pain Medical Treatment Guidelines state that anti-epilepsy drugs are recommended for neuropathic pain. They go on to state that a good outcome is defined as 50% reduction in pain and a moderate response is defined as 30% reduction in pain. Guidelines go on to state that after initiation of treatment, there should be documentation of pain relief and improvement in function as well as documentation of side effects incurred with use. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects. Within the documentation available for review, there is no identification of any specific objective functional improvement. Additionally, there is no discussion regarding side effects from this medication. Antiepileptic drugs should not be abruptly discontinued but unfortunately, there is no provision to modify the current request. As such, the currently requested Gabapentin (Neurontin) is not medically necessary.