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| Case Number: | CM15-0193282 | | |
| Date Assigned: | 10/07/2015 | Date of Injury: | 03/22/2004 |
| Decision Date: | 12/15/2015 | UR Denial Date: | 09/01/2015 |
| Priority: | Standard | Application Received: | 10/01/2015 |

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: Georgia

Certification(s)/Specialty: Anesthesiology, 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 59 year old male, who sustained an industrial injury on 3-22-2004. The injured worker is being treated for lumbar radiculopathy, chronic low back pain, lumbar facet arthropathy and lumbar herniated discs. Treatment to date has included medications and left sided L4-L5 epidural injections on 3-18-2015 and on the right on 5-20-2015. Per the medical records dated 4-16-2015 he reported that it tremendously the pain in the left leg and he has had significant improvement not only subjectively but objectively in regards to left leg pain following the injection. Per the note dated 5-29-2015 he has been having injections which have been giving him benefit. Per the Physician's Supplemental Report dated 8-28-2015, the injured worker presented for orthopedic reevaluation. He reported that his symptoms are still good on the left. He is waiting for his right sided lumbar epidural. His neck is bothering him and he is hoping to have an epidural there as well. There were no objective findings recorded on this date. Per the 7-09-2015 examination he had regression on the left, positive at 50 degrees with some L4-5 dermatomal changes on the left and a positive Lesegue's test. Per the medical records dated 3-09-2015 to 8-28-2015 there is no documentation of improvement in symptoms, increase in activities of daily living or decrease in pain level with attributed to the prescribed medications. The notes from the provider do not document efficacy of the prescribed medications. Work status was temporarily totally disabled. The plan of care on 8-28-2015 included analgesic creams. Authorization was requested for Paxil 40mg, urine toxicology screen, left L4-L5 lumbar transforaminal epidural steroid injection, Gabapentin 100mg, Tizanidine 4mg, and Percocet 10-325mg #60. On 9-01-2015, Utilization Review non-certified the request for one left L4-L5 lumbar transforaminal epidural steroid injection, prescriptions for Gabapentin and

Tizanidine, and modified the request for Percocet.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left transforaminal epidural steroid injection under fluoroscopic guidance at level of L4 and L5: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

Decision rationale: Left transforaminal epidural steroid injection under fluoroscopic guidance at level of L4 and L5 is not medically necessary. The California MTUS page 47 states the purpose of epidural steroid injections is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone is no significant long-term functional benefit. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Initially unresponsive to conservative treatment, injections should be performed using fluoroscopy; if the ESI is for diagnostic purposes a maximum of 2 injections should be performed. No more than 2 nerve root levels should be injected using transforaminal blocks. No more than 1 interlaminar level should be injected at one session. 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 6-8 weeks, with the general recommendation of no more than 4 blocks per region per year. Current research does not support a series of 3 injections in either the diagnostic or therapeutic phase. We recommend no more than 2 epidural steroid injections. The patient had a previous epidural steroid injection without documentation of at least 50% reduction in pain. Therefore, the requested procedure is not medically necessary for not meeting MTUS guidelines.

Percocet 10/325mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use, Opioids for chronic pain, Opioids for neuropathic pain, Opioids for osteoarthritis, Opioids, cancer pain vs. nonmalignant pain, Opioids, dealing with misuse & addiction, Opioids, differentiation: dependence & addiction, Opioids, dosing, Opioids, indicators for addiction, Opioids, long-term assessment, Opioids, pain treatment agreement, Opioids, psychological intervention, Opioids, screening for risk of addiction (tests), Opioids, specific drug list, Opioids, steps to avoid misuse/addiction, Opioid hyperalgesia.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

Decision rationale: Percocet 10/325 mg, #60 is not medically necessary. Per MTUS Page 79 of MTUS guidelines states that weaning of opioids are recommended if: (a) there are no overall improvement in function, unless there are extenuating circumstances. (b) continuing pain with evidence of intolerable adverse effects. (c) decrease in functioning. (d) resolution of pain. (e) if serious non-adherence is occurring. (f) the patient requests discontinuing. The claimant's medical records did not document that there was an overall improvement in function or a return to work with previous opioid therapy. The claimant has long-term use with this medication and there was a lack of improved function with this opioid; therefore the requested medication is not medically necessary.

Gabapentin 100mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs).

Decision rationale: Gabapentin 100 mg is not medically necessary. CA MTUS 17-19 Recommended for neuropathic pain (pain due to nerve damage). There is a lack of expert consensus on the treatment of neuropathic pain in general due to heterogeneous etiologies, symptoms, physical signs and mechanisms. Most randomized controlled trials (RCTs) for the use of this class of medication for neuropathic pain have been directed at post-herpetic neuralgia and painful polyneuropathy (with diabetic polyneuropathy being the most common example). There are few RCTs directed at central pain and none for painful radiculopathy. (Attal, 2006) The choice of specific agents reviewed below will depend on the balance between effectiveness and adverse reactions. Additionally, Per MTUS One recommendation for an adequate trial with gabapentin is three to eight weeks for titration, then one to two weeks at maximum tolerated dosage. (Dworkin, 2003) The patient should be asked at each visit as to whether there has been a change in pain or function. The claimant did not show improved function on his most recent office visit; therefore, the requested medication is not medically necessary.

Tizanidine 4mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

Decision rationale: Tizanidine 4 mg is not medically necessary. Per CA MTUS "Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. There is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. The recommended

dosing is 4mg with a max dose of 36 mg per day." The medical records indicate that the Tizanidine was prescribed for back pain. Tizanidine is recommended short-term use for myofascial pain or fibromyalgia; therefore, the claim is not medically necessary. This request is not medically necessary.