

Case Number:	CM15-0027574		
Date Assigned:	02/19/2015	Date of Injury:	10/15/2011
Decision Date:	04/06/2015	UR Denial Date:	01/16/2015
Priority:	Standard	Application Received:	02/12/2015

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 57 year old male, who sustained a work/ industrial injury on 10/15/11. He has reported symptoms of bilateral low back pain radiating to the right buttock, right lateral thigh, and right lateral calf with numbness of bilateral heels. Prior medical history includes depression secondary to chronic pain. Past surgical history included L5-S1 fusion on 11/27/12. The diagnoses have included FBSS (failed back syndrome) and chronic pain. Treatments to date included medication and prior surgery. Medications included Percocet and Gabapentin. The primary treating physician's progress report noted right L5 radiculopathy, lumbar disc protrusion, and failed back surgery syndrome. There was restricted range of motion in the bilateral lower extremities. Muscle strength was 5/5. A request was made for Fluoroscopy guided spinal cord stimulator trial, OxyContin, and Oxycodone for pain management. On 1/16/15, Utilization Review non-certified a Fluoroscopy guided percutaneous spinal cord stimulator trial; OxyContin 15mg #60; Oxycodone 5/325mg #120 , noting the California Medical treatment Utilization Schedule (MTUS) Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fluoroscopy guided percutaneous spinal cord stimulator trial: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines spinal cord stimulation Page(s): 105-107, 101.

Decision rationale: Per the 01/06/15 report the patient presents with worsened lower back pain and right lower extremity pain with pain radiating to the right heel. The patient's diagnoses include failed back surgery syndrome. The current request is for FLUOROSCOPY GUIDED PERCUTANEOUS. The 01/06/15 report by [REDACTED] states this is for fluoroscopically guided percutaneous spinal cord stimulator trial. The 01/16/15 utilization review states the RFA is dated 01/09/15. The patient is disabled. MTUS Guidelines page 105 to 107 states that spinal cord stimulation is "Recommended only for selected patients in cases when less invasive procedures have failed or contradicted for specific conditions and following a successful temporary trial." Indications for stimulator implantation are failed back syndrome, CRPS, post amputation pain, post herpetic neuralgia, spinal cord injury dysesthesia, pain associated with multiple sclerosis, and peripheral vascular disease. MTUS page 101 states that psychological evaluation is "recommended pre-intrathecal drug delivery systems and spinal cord stimulator trial." The treater states this request is to evaluate and treat the patient's lumbar radiculopathy, failed back syndrome and neuropathic pain that have failed all conservative and surgical treatments. The treater states the patient was psychologically cleared by [REDACTED] PhD. A copy of this 11/20/14 report is included for review and states, "I am clearing to proceed with spinal cord stimulator trial if deemed medically appropriate." The treater cites Lumbar spine xrays that document solid fusion and states that the patient is not a candidate for nor does he desire further spine surgery. The reports provided document clinical evidence that this patient meets indications for SCC and psych clearance has been received. In this case, the request IS medically necessary.

Oxycontin 15mg #60: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 76-78, 88-89.

Decision rationale: Per the 01/06/15 report the patient presents with worsened lower back pain and right lower extremity pain with pain radiating to the right heel. The patient's diagnoses include failed back surgery syndrome. The current request is for OXYCONTIN 15mg #60 an opioid. The 01/16/15 utilization review states the RFA is dated 01/09/15. The patient is disabled. MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. The reports provided for review show the patient has been prescribed this medication since at least 09/16/14. The treater states this

medication provides 50% pain relief. The ODI is stated to be 30-60%, with use of this medication and 39-78% without. The treater states there is a 50% improvement in ADL's including self-care and dressing with use of Oxycotin. The patient has an up-to-date pain contract, the most recent UDS is noted be consistent, the medication has no adverse side effects and the patient shows no adverse behavior. In this case, the 4 A's have been documented as required by the MTUS guidelines. The request IS medically necessary.

Oxycodone 5/325mg #120: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 76-78, 88-89.

Decision rationale: Per the 01/06/15 report the patient presents with worsened lower back pain and right lower extremity pain with pain radiating to the right heel. The patient's diagnoses include failed back surgery syndrome. The current request is for OXYCODONE 5/325mg #120 an opioid. The 01/16/15 utilization review states the RFA is dated 01/09/15. The patient is disabled. MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. The reports provided for review show the patient has been prescribed this medication since at least 09/16/14. The treater states this medication provides 40% pain relief. The ODI is stated to be 30-60%, with use of this medication and 39-78% without. The treater states there is a 40% improvement in ADL's including self-care and dressing with use of Oxycodone. The patient has an up-to-date pain contract, the most recent UDS is noted be consistent, the medication has no adverse side effects and the patient shows no adverse behavior. In this case, the 4A's have been documented as required by the MTUS guidelines. The request IS medically necessary.