

Case Number:	CM15-0087396		
Date Assigned:	06/24/2015	Date of Injury:	01/28/2006
Decision Date:	08/25/2015	UR Denial Date:	04/06/2015
Priority:	Standard	Application Received:	05/06/2015

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:

This is a 56 year old female with a January 28, 2006 date of injury. A progress note dated March 25, 2015 documents subjective complaints (increasing right lower extremity pain; slight symptoms noted in the left lower extremity; has been quite anxious and depressed because of the increasing pain; lower back pain; numbness, tingling, burning, and electrical pain; urinary incontinence; pain rated at a level of 6/10 with medications and 9-10/10 without medications), objective findings (anxious and depressed affect/mood; bilateral lumbar paraspinous tenderness from L1 to S1 with tenderness over the L4-L5 and L5-S1 region; muscle spasms of the lumbar spine; positive straight leg raise bilaterally; decreased strength of the bilateral lower extremities; hyperesthesia in the right greater than left L5 dermatome in addition to S1 greater than L4), and current diagnoses (lower back and lower extremity pain; grade 1 spondylolisthesis at L5-S1 with multilevel degenerative facet disease associated with multilevel advanced degenerative facet disease, and mild foraminal stenosis; chronic and ongoing denervation of the L5 nerve root; insomnia secondary to chronic pain; anxiety and depression secondary to chronic pain). Treatments to date have included medications, lumbar medial branch nerve block without improvement, physical therapy without benefit, did not find acupuncture helpful, electromyogram, and imaging studies. The medical record indicates that medications help control the pain. The treating physician documented a plan of care that included Norco, Laxacin, a right transforaminal epidural steroid injection, and transportation to and from the surgery center.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325mg, #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain CRITERIA FOR USE OF OPIOIDS Page(s): 60, 61, 88, 89, 76-78.

Decision rationale: The patient was injured on 03/31/15 and presents with low back pain, increasing right lower extremity pain and left lower extremity pain which travels post laterally down the lower extremities, anxiety, and depression. The request is for NORCO 10/325 MG #60 for breakthrough pain. The utilization review determination rationale is that there is "insufficient functional and quantified benefit to justify the dose." The RFA is dated 03/31/15 and the patient's current work status is not provided. The patient has been taking Norco as early as 12/10/14 and treatment reports are provided from 12/10/14 to 04/06/15. 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. MTUS page 98 also continues to state that the maximum dose of hydrocodone is 60 mg per day. Pages 80, 81 of MTUS also states "There are virtually no studies of opioids for treatment of chronic lumbar root pain with resultant radiculopathy," and for chronic back pain, it "Appears to be efficacious but limited for short-term pain relief, and long-term efficacy is unclear (>16 weeks), but also appears limited." The 01/28/15 and 02/26/15 reports state that the patient rates her pain as a 4-6/10 with medications and a 9-10/10 without medications. The patient currently notes 40% to 50% improvement in pain and function with the current regimen and allows her to perform her activities of daily living including self-hygiene, light household chores, and meal preparation. The patient states with medication she is able to go grocery shopping. She notes being able to walk for longer distances with medications. The patient denies any adverse side effects other than constipation. She continues to utilize her medications as prescribed. She has a signed pain medication agreement and continues to be compliant. She has completed urine drug screening which showed consistency with prescribed medications. The patient also has completed an opioid risk assessment profile and was found to be at low risk for opioid abuse. The 03/25/15 report states that the patient rates her pain as a 6/10 with medications and a 9-10/10 without medications. The 02/26/15 urine drug screen provided for review indicates that the patient is compliant with her prescribed medications. In this case, all of the 4 As are addressed as required by MTUS Guidelines. There are before and after medication pain scales, examples of ADLs which demonstrate medication efficacy, and the patient does not have any adverse behavior/side effects besides constipation. The patient has a signed pain medication agreement on file and is consistent with her prescribed medications. The treating physician provides proper documentation that is required by MTUS Guidelines for continued opiate use. Therefore, the requested Norco IS medically necessary.

Laxacin 50/8.6mg, #120: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Constipation Page(s): 77.

Decision rationale: The patient was injured on 03/31/15 and presents with low back pain, increasing right lower extremity pain and left lower extremity pain which travels post laterally down the lower extremities, anxiety, and depression. The request is for LAXACIN 50/8.6 MG #120 as needed for opioid-induced constipation. The utilization review determination rationale is that guidelines offer no support for proprietary stool softening agents. The RFA is dated 03/31/15 and the patient's current work status is not provided. The patient has been taking this medication as early as 01/25/15. Regarding constipation, MTUS Chronic Pain Medical Treatment Guidelines, page 77, states that prophylactic treatment of constipation should be initiated with therapeutic trial of opioids. It also states "Opioid induced constipation is a common adverse side effect of long-term opioid use." The 02/26/15 report states that with Norco, "the patient denies any adverse side effects other than constipation." The treater would like Laxacin for the patient's opioid-induced constipation, as indicated by MTUS guidelines. The patient has been taking Norco as early as 12/10/14 and Laxacin is an appropriate intervention for those undergoing long-term opiate use. Therefore, this request IS medically necessary.

Right L4-5 Transforaminal ESI Under Fluoroscopic Guidance: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection (ESI).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ESI Epidural Steroid Injections Page(s): 46, 47.

Decision rationale: The patient was injured on 03/31/15 and presents with low back pain, increasing right lower extremity pain and left lower extremity pain which travels post laterally down the lower extremities, anxiety, and depression. The request is for RIGHT L4-5 TRANSFORAMINAL ESI UNDER FLUOROSCOPIC GUIDANCE. The RFA is dated 03/31/15 and the patient's current work status is not provided. The 01/28/15 report states that the patient "has previously undergone three lumbar epidural steroid injections, which she did not find beneficial." In regards to epidural steroid injections, MTUS page 46-47 has the following criteria under its chronic pain section: "radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing... 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." The patient has bilateral lumbar paraspinous tenderness from L1 to S1 with tenderness over the L4-L5 and L5-S1 region, 1 to 2+ muscle spasms, a limited lumbar spine range of motion, a positive straight leg raise on the right at 30 degrees and positive

on the left at 40 degrees, and hypesthesia in the right greater than left L5 dermatome in addition to S1 greater than L4. She has mild foraminal stenosis at right L4-L5 and L5-S1 with lateral recess at L4-L5 bilaterally (07/02/14 MRI). It appears that the patient has had 3 prior lumbar epidural steroid injections. However, there is no indication of when these injections occurred. MTUS Guidelines require "at least 50% pain relief with associated reduction of medication use for 6 to 8 weeks," for repeat blocks. In this case, there is no numerical value provided regarding how much benefit the patient had from the prior ESI. The 01/28/15 report indicates that the patient did not receive any benefit from prior ESI. The requested lumbar epidural steroid injection IS NOT medically necessary.

Transportation to / from Surgery center: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee chapter under Transportation and Other Medical Treatment Guidelines www.aetna.com : Transportation.

Decision rationale: The patient was injured on 03/31/15 and presents with low back pain, increasing right lower extremity pain and left lower extremity pain which travels post laterally down the lower extremities, anxiety, and depression. The request is for TRANSPORTATION TO/FROM SURGERY CENTER. The RFA is dated 03/31/15 and the patient's current work status is not provided. ODG-TWC guidelines, Knee chapter under Transportation (to & from appointments) states: "Recommended for medically-necessary transportation to appointments in the same community for patients with disabilities preventing them from self-transport (CMS, 2009)." AETNA has the following guidelines on transportation: "The cost of transportation primarily for and essential to, medical care is an eligible medical expense. The request must be submitted for reimbursement and the request should document that patient cannot travel alone and requires assistance of a nurse or companion." The patient has bilateral lumbar paraspinal tenderness from L1 to S1 with tenderness over the L4-L5 and L5-S1 region, 1 to 2+ muscle spasms, a limited lumbar spine range of motion, a positive straight leg raise on the right at 30 degrees and positive on the left at 40 degrees, and hypesthesia in the right greater than left L5 dermatome in addition to S1 greater than L4. The treater does not provide a rationale for this request. In this case, there is no mention that the patient has disabilities preventing him from self-transport. There is no evidence that the patient is unable to travel alone or that assistance is required either. Therefore, the request IS NOT medically necessary.