

<b>Case Number:</b>	CM14-0146937		
<b>Date Assigned:</b>	09/15/2014	<b>Date of Injury:</b>	03/18/2001
<b>Decision Date:</b>	10/16/2014	<b>UR Denial Date:</b>	09/05/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/10/2014

### 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. The expert reviewer is Board Certified in Internal Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is an injured worker with a lumbosacral condition. Date of injury was 03-18-2001. Progress report dated 8/26/14 documented subjective complaints of low back and left lower extremity pain. He has significant low back with radiation to the left lower extremity. He rates his pain as 8/10 on the daily basis. He reports his pain has impaired his ability to do his daily activities. He cannot lift over 10 lbs over head without pain. He cannot stand or walk or sitting for 15 minutes. The pain impairs his ability to play sports. It also has had a negative impact emotionally causing problems with concentration, mood, sleep. His latest repeat urine drug screen was consistent with medications prescribed, this patient is compliant and reliable. Medications were Percocet 10/325 mg every 4 hrs and Ambien. The patient is status post TLIF transforaminal lumbar interbody fusion surgery at L5-S1 performed in 2003. He is status post four wrist surgeries. Physical examination was documented. The patient was normally developed, well groomed, in no acute distress. There were no assistive devices used for walking. The patient has a normal affect. The patient was making good eye contact. Judgement appeared good. Range of motion of the lumbar spine is full in flexion, extension, lateral rotation and lateral bending with an increase in concordant pain in all planes. Motor strength is 5/5 bilateral lower extremities. Straight leg raise test was positive left for radicular signs and symptoms at 60 degrees. Diagnoses were displacement intervertebral disc lumbar, degeneration of lumbar intervertebral disc, and low back pain. Treatment plan included a continuation of Percocet and Ambien. Left TFESI transforaminal epidural steroid injections at L4 and L5 and S1 (three levels) were requested. Utilization review determination date was 9/5/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**AMBIEN 10MG #20:**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) Zolpidem (Ambien)

**Decision rationale:** Medical Treatment Utilization Schedule (MTUS) does not address Ambien. Official Disability Guidelines (ODG) states that Ambien is approved for the short-term, usually two to six weeks, treatment of insomnia, and should be used for only a short period of time. Medical records indicate long-term use of Ambien. ODG guidelines states that Ambien should be used for only a short period of time. The long-term use of Ambien is not supported by ODG guidelines. Therefore, the request for AMBIEN 10MG #20 is not medically necessary.

**PERCOCET 10/325MG #150:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Oxycodone/Acetaminophen (Percocet) Page(s): 74-96, 92.

**Decision rationale:** Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines (page 89) present the strategy for maintenance for long-term users of opioids. "Do not attempt to lower the dose if it is working." Supplemental doses of breakthrough medication may be required for incidental pain, end-of dose pain, and pain that occurs with predictable situations. The standard increase in dose is 25 to 50% for mild pain and 50 to 100% for severe pain. Percocet should be administered every 4 to 6 hours as needed for pain. For more severe pain the dose (based on Oxycodone) is 10-30mg every 4 to 6 hours prn pain. The medical records document that the patient's long-term medication regimen has included the prescription of Percocet 10/325 mg. The patient has regular clinic visits for reassessment. Progress report dated 8/26/14 documented significant low back pain. The patient is status post TLIF transforaminal lumbar interbody fusion surgery at L5-S1. His latest repeat urine drug screen was consistent with medications prescribed. The patient was characterized as compliant and reliable. Medical records document the stable use of opioid medications and objective evidence of pathology. Medical records support the maintenance of the Percocet 10/325 mg prescription. Therefore, the request for PERCOCET 10/325MG #150 is medically necessary.

**1 LEFT SIDED TRANSFORAMINAL EPIDURAL STEROID INJECTION AT L4,L5 AND S1 UNDER FLUOROSCOPIC GUIDANCE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines EPIDURAL STEROID INJECTION S.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300,Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46.

**Decision rationale:** Medical Treatment Utilization Schedule (MTUS) addresses epidural steroid injections (ESIs). American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 12 Low Back Complaints (Page 300) states that invasive techniques (e.g., local injections and facet-joint injections of cortisone and lidocaine) are of questionable merit. Epidural steroid injections treatment offers no significant long-term functional benefit, nor does it reduce the need for surgery. MTUS Chronic Pain Medical Treatment Guidelines (Page 46) state that epidural steroid injections (ESIs) are recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). The American Academy of Neurology concluded that epidural steroid injections do not affect impairment of function or the need for surgery and do not provide long-term pain relief. ESI treatment alone offers no significant long-term functional benefit. Criteria for the use of epidural steroid injections requires that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. No more than two nerve root levels should be injected using transforaminal blocks. No more than one 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 six to eight weeks. Current research does not support a series-of-three injections in either the diagnostic or therapeutic phase. Most current guidelines recommend no more than 2 ESI injections. No more than 2 ESI injections are recommended. Left TFESI transforaminal epidural steroid injections at L4 and L5 and S1 (three levels) were requested. Progress report dated 8/26/14 documented that the range of motion of the lumbar spine was full in flexion, extension, lateral rotation, and lateral bending. Motor strength was 5/5 bilateral lower extremities. No tenderness was documented on physical examination. No plain film x-ray, MRI, or CT scan results were documented. MTUS guidelines require corroboration by imaging studies or electrodiagnostic testing. Medical records do not support the medical necessity of lumbosacral epidural steroid injections. Therefore, the request for 1 LEFT SIDED TRANSFORAMINAL EPIDURAL STEROID INJECTION AT L4,L5 AND S1 UNDER FLUOROSCOPIC GUIDANCE is not medically necessary.