

<b>Case Number:</b>	CM15-0013641		
<b>Date Assigned:</b>	02/02/2015	<b>Date of Injury:</b>	09/27/2004
<b>Decision Date:</b>	03/19/2015	<b>UR Denial Date:</b>	01/10/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/23/2015

### 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: North Carolina  
 Certification(s)/Specialty: Family Practice

### 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 32 year old male, who sustained an industrial injury on September 27, 2004. The diagnoses have included major depressive disorder with psychotic features, lumbar disc displacement without myelopathy, lumbar disc degeneration, lumbar spinal stenosis, and cervical disc displacement. Treatment to date has included acupuncture, chiropractic treatments, bracing, psychiatric care, epidural steroid injection, and medications. Currently, the injured worker complains of lower back pain, anxiety, and depression. The Treating Physician's noted dated January 5, 2015, noted the injured worker had a recent increase in back pain and leg weakness that brought him to the emergency room. The lumbar spine was noted with significant pain with range of motion exercises, with spasm and guarding. On January 10, 2015, Utilization Review non-certified a lumbar epidural steroid injection at L4-L5 and L5-S1 and one prescription of Morphine sulfate ER 30mg #120. The UR Physician noted the examination on January 5, 2015, noted the injured worker's lower extremity weakness symptomology had resolved and no exam findings were documented to suggest active an clinical radicular component to the injured worker's pain, therefore the request for a lumbar epidural steroid injection at L4-L5 and L5-S1 was non-certified, citing the MTUS Chronic Pain Medical Treatment Guidelines and non-MTUS guidelines. The UR Physician noted that to allow for continuation of guidelines supported weaning in the absence of demonstrated effectiveness to warrant continued use, the request for one prescription of Morphine sulfate ER 30mg #120 was modified to certify #23 tablets, with the additionally requested #97 tablets non-certified, citing the MTUS Chronic Pain Medical Treatment Guidelines. On January 23, 2015, the injured

worker submitted an application for IMR for review of a lumbar epidural steroid injection at L4-L5 and L5-S1 and one prescription of Morphine sulfate ER 30mg #120.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **1 lumbar epidural steroid injection at L4-L5 and L5-S1: Overturned**

**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 epidural steroid injections Page(s): 46.

**Decision rationale:** The California chronic pain medical treatment guidelines section on epidural steroid injections (ESI) states: Criteria for the use of Epidural steroid injections: Note: The purpose of ESI 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 offers no significant long-term functional benefit. 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). 3) Injections should be performed using fluoroscopy (live x-ray) for guidance. 4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections. 5) No more than two nerve root levels should be injected using transforaminal blocks. 6) No more than one interlaminar level should be injected at one session. 7) 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. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007) 8) Current research does not support a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections. The patient has the documentation of low back pain and lumbar radiculopathy as demonstrated on physical exam and corroborated by previous MRI. The patient has failed conservative therapy including physical therapy and acupuncture. All criteria have been met as set forth above and the request is certified.

#### **1 prescription of Morphine Sulfate ER 30mg #120: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Morphine; Opioids, On-going Management; Long-term Users of Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 76-84.

**Decision rationale:** The California chronic pain medical treatment guidelines section on opioids states for ongoing management: On-Going Management. Actions Should Include: (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy. (b) The lowest possible dose should be prescribed to improve pain and function. (c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or nonadherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. (Passik, 2000) (d) Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain diary that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management. (e) Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control. (f) Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion). (g) Continuing review of overall situation with regard to nonopioid means of pain control. (h) Consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consult if there is evidence of substance misuse. When to Continue Opioids: (a) If the patient has returned to work (b) If the patient has improved functioning and pain (Washington, 2002) (Colorado, 2002) (Ontario, 2000) (VA/DoD, 2003) (Maddox-AAPM/APS, 1997) (Wisconsin, 2004) (Warfield, 2004) The long-term use of this medication class is not recommended per the California MTUS unless there documented evidence of benefit with measurable outcome measures and improvement in function. There is no documentation of significant subjective improvement in pain such as VAS scores. Most of the subjective documentation states the pain is a 9/10 with medications. There is also no objective measure of improvement in function. For these reasons the criteria set forth above of ongoing and continued used of opioids have not been met. Therefore the request is not certified.