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| Case Number: | CM15-0015277 | | |
| Date Assigned: | 02/03/2015 | Date of Injury: | 02/01/2011 |
| Decision Date: | 03/24/2015 | UR Denial Date: | 12/31/2014 |
| Priority: | Standard | Application Received: | 01/27/2015 |

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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & Gen Prev Med

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 43 year old male, who sustained an industrial injury on 02/01/2011. He has reported low back pain. The diagnoses have included bilateral shoulder impingement and partial ankylosis; lumbosacral sprain/strain with chronic lumbago; bilateral lumbar radiculitis; lumbar disc disease; and chronic pain syndrome. Treatment to date has included medications and surgical intervention. Medications have included Norco, Ibuprofen, and Soma. A progress note from the treating physician, dated 12/01/2014, documented a follow-up visit with the injured worker. The injured worker has reported severe low back pain with bilateral leg radiation and numbness and tingling; and bilateral shoulder pain. Objective findings included moderate to severe tenderness over the paraspinal muscles of the lumbar spine and over the bilateral gluteus region; straight-leg raising test is positive bilaterally; and slight antalgic gait. The treatment plan has included request for medication prescriptions including Zohydro; request for chronic pain functional rehab program; request for lumbar epidural steroid injection; and follow-up evaluation in one month. On 12/31/2014 Utilization Review noncertified a request for Zohydro 30 mg #60; Functional Rehab Program Consult; and Lumbar Epidural Steroid Injection at L4-5, L5-S1. The CA MTUS was cited. On 01/20/2015, the injured worker submitted an application for IMR for review of Zohydro 30 mg #60; Functional Rehab Program Consult; and Lumbar Epidural Steroid Injection at L4-5, L5-S1.

IMR ISSUES, DECISIONS AND RATIONALES

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

Zohydro 30mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 63,76-80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96. Decision based on Non-MTUS Citation Pain, Opioids

Decision rationale: Zohydro is a brand name version of Hydrocodone. ODG does not recommend the use of opioids for low back pain, "except for short use for severe cases, not to exceed 2 weeks." The patient has exceeded the 2 week recommended treatment length for opioid usage. MTUS does not discourage use of opioids past 2 weeks, but does state that, "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." The treating physician does not fully document the least reported pain over the period since last assessment, intensity of pain after taking opioid, pain relief, increased level of function, or improved quality of life. Additionally, medical documents indicate that the patient has been on Norco, which is also an opioid in excess of the recommended 2-week limit for opioids. As such, the question for 1 prescription of Zohydro 30mg #60 is not medically necessary.

Functional Rehab Program Consult: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional restoration program Page(s): 30.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Program, Detoxification, Functional Restoration Programs Page(s): 30-34, 42, 49.

Decision rationale: MTUS states regarding the general use of multidisciplinary pain management programs:(1) An adequate and thorough evaluation has been made, including baseline functional testing so follow-up with the same test can note functional improvement(2) Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement;(3) The patient has a significant loss of ability to function independently resulting from the chronic pain; (4) The patient is not a candidate where surgery or other treatments would clearly be warranted (if a goal of treatment is to prevent or avoid controversial or optional surgery, a trial of 10 visits may be implemented to assess whether surgery may be avoided); (5) The patient exhibits motivation to change, and is willing to forgo secondary gains, including disability payments to effect this change;(6) Negative predictors of success above have been addressed.The current request is for a functional restoration program evaluation. While the guidelines address adequacy of entry into a program, a few criteria are important to note prior to an evaluation. The treating physician notes that surgery

has been recommended for this patient, but the patient has declined. Additionally, the treating physician does not adequately document a significant loss of ability to function due to chronic pain. Subjective pain is documented, but medical records related to the request for the functional restoration program evaluation do not detail what abilities are lost specifically due to pain. As such, the request for Functional Rehab Program Consult is not medically necessary at this time.

Lumbar Epidural Steroid Injection at L4-5, L5-S1: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315,Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46. Decision based on Non-MTUS Citation Low Back - Lumbar & Thoracic (Acute & Chronic), Epidural steroid injections (ESIs), therapeutic

Decision rationale: MTUS Chronic pain medical treatment guidelines state that epidural steroid injections are, "Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy) . . . Epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program." There were no medical documents provided to conclude that other rehab efforts or home exercise program is ongoing. Additionally, no objective findings were documented to specify the dermatomal distribution of pain. MTUS further defines the criteria for epidural steroid injections to include: 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. Radiculopathy does appear to be documented with imaging studies. The patient is taking multiple medications, but the progress reports do not document how long the patient has been on these medications and the "unresponsiveness" to the medications. The treating physician has noted that this patient has had previous ESIs without significant functional improvement. Additionally, treatment notes do not indicate if other conservative treatments were tried and failed (exercises, physical therapy, etc). As such, the request for Lumbar Epidural Steroid Injection at L4-5, L5-S1 is not medically necessary.