

Case Number:	CM15-0113953		
Date Assigned:	07/21/2015	Date of Injury:	09/03/2009
Decision Date:	08/17/2015	UR Denial Date:	06/02/2015
Priority:	Standard	Application Received:	06/11/2015

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 (IW) is a 55 year old female who sustained an industrial injury on 09/03/2009. She reported being struck by a falling gate striking her right shoulder and low back. The worker had increased low back pain radiating into the left leg as well as right shoulder pain. She has a history of prior work related slip and fall injury in 1997 and underwent anterior discectomy and fusion at the L4-5 and L5-S1 levels (12/1999). The injured worker was diagnosed as having chronic intractable pain syndrome, osteoarthritis right knee, chronic low back pain, sciatica, postlaminectomy syndrome in lumbar region L4-5/ L5-S1 fusion. Treatment to date has included lumbar epidural steroid injections (LESI), oral medications and a series of right knee Supartz injections. Currently, the injured worker complains of pain in her back and right knee that keeps her awake at night. The pain is described as constant and interferes with her ability to perform daily activities, driving and home chores. On examination, the cervical spine has tenderness to palpation and the anterior surgical scar has mild spasm of the left thoracolumbar paraspinals. She has increased end range of motion stiffness and tenderness and increased tenderness at the left sciatic, tibial and peroneal nerves. Soft tissue tenderness is greater into the left leg. Her gait is antalgic to the left. Shoulder strength is normal bilaterally. She has increased paresthesias left L4 and L5 affecting all of the areas. Her relief from past LESI (01/15/2015) gave greater than 50% initial pain relief followed by greater than 50% relief for more than two months. Her Supartz viscosupplementation injection of the right knee gave six months of relief greater than 70% Both interventions helped her increase her daily activity of daily living toleration, and ability to extend her activities into cleaning her house and other active pursuits. The treatment plan is to repeat the Left L4-5 LESI, refill medications and

administer additional Supartz viscosupplementation. A request for authorization was made for the following: 1. Nucynta 50mg #180 2. Morphine sulfate (MS) ER 50mg #60 3. Left L4-L5 transforaminal epidural/selective nerve root blocks 4. Right knee Supartz viscosupplementation #5.

IMR ISSUES, DECISIONS AND RATIONALES

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

Nucynta 50mg #180: 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), Nucynta.

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 non-adherent) 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 non-opioid 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 documented significant improvement in VAS scores for significant periods of time. There are no objective measurements of improvement in function. Therefore all criteria for the ongoing use of opioids have not been met and the request is not medically necessary.

Left L4-L5 transforaminal epidural/selective nerve root blocks: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of epidural steroid injections.

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 with radicular symptoms. Review of the provided records show criteria for repeat ESI have been met and the request is medically necessary.