

Case Number:	CM15-0160902		
Date Assigned:	09/23/2015	Date of Injury:	08/15/2002
Decision Date:	11/02/2015	UR Denial Date:	08/04/2015
Priority:	Standard	Application Received:	08/17/2015

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 59-year-old male, with a reported date of injury of 08-15-2002. The diagnoses include lumbosacral spondylosis without myelopathy, other pain disorder related psychological factors, major depressive disorder recurrent episode, generalized anxiety disorder, cervical radiculopathy, lumbar failed back syndrome, lumbar spine radiculopathy, fibromyalgia, and unspecified derangement of medial meniscus. Treatments and evaluation to date have included Norco, Neurontin, Morphine (since at least 03-2015), Percocet, Soma, Lyrica, Flexeril, Baclofen, Zolof, trigger point injections, Dexa scan on 03-17-2015 which showed osteopenia of the right hip, and left knee arthroscopy on 04-07-2015. The diagnostic studies to date have included a urine drug test dated 02-02-2015 which was positive for Morphine; a CT scan of the cervical spine on 06-30-2015 which showed straightening of the normal cervical lordosis, status post interbody fusion from C5-T1, minimal anterolisthesis at C4-5, minimal disk osteophyte complexes from C3-4 through C6-7, facet hypertrophy, mild to moderate from C4-5 through C6-7, no bony central canal stenosis, and bony neural foraminal stenosis, mild to moderate on the right at C7-T1; and an MRI of the cervical spine on 10-06-2014 which showed disk desiccation at C2-3, C3-4, and C4-5 and disk fusion at C5-6, C6-7, and C7-T1. The progress report dated 07-13-2015 indicates that the injured worker complained of low back pain, cervical spine pain, and right shoulder pain. The treating physician noted that the injured worker had right neural foraminal narrowing at C7-T1. The injured worker had right neck pain that was described as shooting pain down the right arm, back, and up the neck. The treating physician indicated that the injured worker was interested in a cervical epidural steroid injection. He rated his pain 5 out of 10 at its least, and 9 out of 10 at its worst. The pain was presently rated 7 out of 10. The physical examination showed tenderness and stiffness of the cervical spine bilateral paraspinous;

palpable twitch positive trigger points in the muscles of the head and neck; anterior flexion of the cervical spine at 30 degrees; pain with anterior neck flexion; cervical spine extension at 15 degrees; pain with extension of the cervical spine; left lateral rotation of the cervical spine at 55 degrees; pain with left lateral rotation of the cervical spine; pain with lumbar extension; and pain with left later flexion of the lumbar spine. The treating physician indicated that analgesia, activities of daily living, adverse side effects, and aberrant drug taking behavior are monitored; every effort is made to assess the pain at every visit and functioning is measured at six-month intervals; a pain agreement is signed and kept on file; and the injured workers are monitored by means of a CURES report and urine drug screen. The progress reports dated 05-06-2015 and 06-08-2015 did not indicate the injured worker's pain ratings. The injured worker's work status was referred to the primary treating physician. The treating physician requested one transforaminal epidural steroid injection at C7-T1 under fluoroscopy and monitored anesthesia care and Morphine ER (extended-release) 15mg #60. On 08-04-2015, Utilization Review (UR) non-certified the request for one transforaminal epidural steroid injection at C7-T1 under fluoroscopy and monitored anesthesia care and modified the request for Morphine ER (extended-release) 15mg #60 to Morphine ER 15mg #48.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 transforaminal epidural steroid injection at C7-T1 under fluoroscopy and monitored anesthesia care: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

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 percent 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 neck pain and there is included imaging or nerve conduction studies in the clinical documentation provided for review that collaborates dermatomal radiculopathy found on exam for the requested level of ESI. Therefore, criteria have been met and the request is medically necessary.

1 prescription of Morphine ER 15mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

Decision rationale: The California chronic pain medical treatment guidelines section on opioids states for ongoing 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 or activity specifically due to the medication. Therefore, all criteria for the ongoing use of opioids have not been met and the request is not medically necessary.