

Case Number:	CM15-0167991		
Date Assigned:	09/08/2015	Date of Injury:	12/07/2005
Decision Date:	12/07/2015	UR Denial Date:	08/12/2015
Priority:	Standard	Application Received:	08/26/2015

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: California, Oregon, Washington
Certification(s)/Specialty: Orthopedic Surgery

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 46 year old female, who sustained an industrial injury on 12-7-05. The injured worker was diagnosed as having degeneration of lumbar or lumbosacral intervertebral disc; lumbago; lumbar postlaminectomy syndrome; chronic pain syndrome; lumbosacral radiculopathy; sacroiliitis NEC; lumbar facet joint pain; myalgia and myositis unspecified; dysesthesia. Treatment to date has included status post L5-S1 interbody and intertransverse fusion with instrumentation (8-2006); physical therapy; medications. Currently, the PR-2 notes dated 8-6-15 indicated the injured worker complains of chronic low back pain "in the setting of lumbar DDD [degenerative disc disease] and lumbar radiculopathy. The patient has pain post fusion L5-S1 with instrumentation". She presents on this day for her routine visit and medication refills. The provider documents "Without pain medications her pain is 10 out of 10 and will medications pain is 7-8 out of 10." She continues unable to walk "due to pain and now is experiencing left foot drop and leg dysfunction with ambulatory problems as her left leg is giving out from underneath her while ambulating. She walks with a cane and cannot walk more than a block. She cannot sleep well and is not able to participate in family events or activities of daily living. She is concerned about this." She reports that physical therapy and acupuncture have been denied. He reports the injured worker has failed conservative measures such as NSAIDS, exercise, ice and heat. He notes she is experiencing increased weakness with pain levels very concerning. She was also denied the requested epidural and has not had one since 2011. He reports she is unable to reduce per pain medication and feels an epidural would allow this. On physical examination, the provider documents "Tender and tight over the posterior neck

with restricted range of motion at least 30% all planes. Today, again with severe tenderness over the paraspinal musculatures, greatest on the left. Positive straight leg raise bilaterally with restriction of flexion no 90% restricted with radicular pain and unable to extend. Left leg strength now 3 out of 5 and right 5 out of 5." He reviews her lumbar MRI dated 6-28-15 reporting: "L2-3 new left foraminal disc protrusion contacting but not impinging exiting left L2 root. Progressive L3-4 disc space narrowing at the level of fusion. L4-5 disc bulge protrusion eccentric to the right causing severe right subarticular gutter stenosis and may be impinging descending right L4 root." The provider's treatment plan includes a request for medications. He is requesting and the epidural steroid injection. A PR-2 note dated 5-26-15 is documented by the provider noting "presents today for her routine visit and medications refills. Without medications per pain is 10 out of 10 and with medications pain is 10 out of 10. Patient says she has been losing weight about 60 pounds, she is going to see her PCP, and is a smoker. She is tearful on this day, her pain has increased since the last time and the request for muscle relaxer was denied and she is using Lyrica with pain medications. We have re-requested the lumbar MRI and awaiting authorization." This PPR-2 note indicates the injured worker is also prescribed Oxycodone IR 15mg. A Request for Authorization is dated 8-26-15. A Utilization Review letter is dated 8-12-15 and non-certification for Oxycodone IR 20mg #150 and Bilateral L3-4, L4-5 transforaminal epidural steroid injection. A request for authorization has been received for Oxycodone IR 20mg #150 and Bilateral L3-4, L4-5 transforaminal epidural steroid injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycodone IR 20mg #150: 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, criteria for use, Opioids, specific drug list. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain / Opioids for chronic pain.

Decision rationale: According to the CA MTUS/Chronic Pain Medical Treatment Guidelines, opioids (criteria for use & specific drug list): A therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. The patient should have at least one physical and psychosocial assessment by the treating doctor (and a possible second opinion by a specialist) to assess whether a trial of opioids should occur. Before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals. Guidelines recommend 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 4 A's for Ongoing Monitoring include analgesia, activities of daily living, adverse side effects, and aberrant drug- taking behaviors. Opioids may be continued if the patient has returned to work and the patient has improved

function/pain. The ODG-TWC pain section comments specifically on criteria for the use of drug screening for ongoing opioid treatment. The ODG Pain / Opioids for chronic pain states According to a major NIH systematic review, there is insufficient evidence to support the effectiveness of long-term opioid therapy for improving chronic pain, but emerging data support a dose-dependent risk for serious harms. Based upon the records reviewed there is insufficient evidence to support chronic use of narcotics. There is lack of demonstrated functional improvement, demonstration of urine toxicology compliance, return to work, or increase in activity from the exam note of 5/26/10. Therefore the determination is for not medically necessary.

Bilateral L3-4, L4-5 transforaminal epidural steroid injection: 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): Epidural steroid injections (ESIs).

Decision rationale: According to the CA MTUS Chronic Pain Medical Treatment Guidelines, Epidural injections, page 46, Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). Specifically the guidelines state that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Research has now shown that, on average, less than two injections are required for a successful ESI outcome. Current recommendations suggest a second epidural injection if partial success is produced with the first injection and a third ESI is rarely recommended. 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. The American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular lumbosacral pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months. In addition there must be demonstration of unresponsiveness to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). CA MTUS criteria for epidural steroid injections are: 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. In this case the exam notes from 8/6/15 do not demonstrate a clear evidence of a dermatomal distribution of radiculopathy. No more than one interlaminar level should be injected at one session. No more than one interlaminar level should be injected at one session. Therefore the determination is for not medically necessary.