

Case Number:	CM15-0177666		
Date Assigned:	09/18/2015	Date of Injury:	01/12/2012
Decision Date:	10/21/2015	UR Denial Date:	08/12/2015
Priority:	Standard	Application Received:	09/09/2015

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 64 year old male who sustained an injury on 1-12-12. Diagnoses include lumbar disc degeneration; lumbar facet arthropathy, lumbar radiculitis and lumbar spinal stenosis. Conservative treatment included drug therapy, acupuncture, chiropractic and physical therapy. The records indicate he has been taking Vicodin since at least 6-9-14. 7-16-15 examination indicates he has low back pain radiating down the right lower extremity; numbness in the bilateral lower extremities to the level of the hips to the level of the thighs and knees. The pain is sharp and moderate to severe in intensity aggravated by activity, bending, prolonged sitting, and standing, twisting and walking. It is improved by sitting and taking medications. His pain was rated 0 out of 10 with medications and was improved since his last visit. The IW reports activity and ambulation are limited and rated 9 out of 10 on a scale of unable to carry on any activities. Lumbar examination reveals no gross abnormality; no spasm in the lumbar spine region; tenderness upon palpation in the paravertebral area L2-S1 levels. Range of motion showed decreased flexion limited to 45 degrees due to pain and extension limited to 10 degrees due to pain. Straight leg raise at 90 degrees sitting position is negative bilaterally. Diagnostic tests reviewed included MRI lumbar spine 5-24-12; MRI left and right hip, and electrodiagnostic nerve conduction tests. He has failed conservative treatment including drug therapy, activity modification, and physical therapy and would like to try lumbar epidural steroid injection to reduce pain and inflammation, restoring range of motion and avoid surgery. He is to continue home exercise program and Vicodin 5-300 mg 1 every 8 hours as needed for pain. Current requested treatments include Vicodin 5, 300 mg #90 with one refill; lumbar transforaminal

epidural steroid injection at bilateral L3-4, L4-5 under fluoroscopy. Utilization review 8-12-15 lumbar transforaminal epidural steroid injection at bilateral L3-4, L4-5 under fluoroscopy non-certified; Vicodin 5,300 mg #90 modified to wean the IW one month supply for weaning purposes at the treating physicians discretion.

IMR ISSUES, DECISIONS AND RATIONALES

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

Vicodin 5/300mg #90 with one refill: 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: 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 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.

Lumbar Transforaminal ESI (epidural steroid injection) at Bilateral L3-4, L4-5, under fluoroscopy: 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: 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 back pain however there is no 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 not been met and the request is not medically necessary.