

Case Number:	CM15-0072214		
Date Assigned:	04/22/2015	Date of Injury:	02/13/2008
Decision Date:	06/08/2015	UR Denial Date:	03/26/2015
Priority:	Standard	Application Received:	04/16/2015

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

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 51 year old male, who sustained an industrial injury on 2/13/2008. Diagnoses include lumbar sprain/strain with bilateral radiculopathy with multilevel disc protrusion/stenosis at L3-S1, retrolisthesis L5-S1, facet hypertrophy L4-S1 and transitional segment L5-6. Treatment to date has included diagnostics, medications, physical therapy, home exercise and pool therapy. Per the hand written Primary Treating Physician's Progress Report dated 3/03/2015, the injured worker reported lower back pain with radiation to the left lower extremity with numbness and tingling. Physical examination of the lumbar spine revealed tenderness to the paravertebral musculature and bilateral sciatic notch with spasm and decreased range of motion. There was a positive straight leg raise test with radiation to the bilateral feet, right greater than left. The plan of care included medications and injections and authorization was requested for Norco 10/325mg, Pamelor 10/25mg and bilateral 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:

Norco 10/325mg, per 03/03/2015 order, qty: 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, specific drug list; Weaning of Medications Page(s): 91; 78-80; 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 44, 47, 75-79, 120 of 127.

Decision rationale: Regarding the request for Norco (hydrocodone/acetaminophen), California Pain Medical Treatment Guidelines state that this is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is no indication that the medication is improving the patient's function (in terms of specific examples of functional improvement and percent reduction in pain or reduced NRS) and there is no documentation of monitoring for appropriate medication usage. As such, there is no clear indication for ongoing use of the medication. Opioids should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In light of the above issues, the currently requested Norco (hydrocodone/acetaminophen) is not medically necessary.

Bilateral L4-L5 transforaminal epidural steroid injection, per 03/03/2015 order, qty: 2:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20-9792.26 Page(s): 46.

Decision rationale: Regarding the request for Bilateral L4-L5 transforaminal epidural steroid injection, Chronic Pain Medical Treatment Guidelines state that epidural injections are recommended as an option for treatment of radicular pain, defined as pain in dermatomal distribution with corroborative findings of radiculopathy, and failure of conservative treatment. Guidelines recommend that no more than one interlaminar level, or to transforaminal levels, should be injected at one session. Regarding repeat epidural injections, guidelines state that 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. Within the documentation available for review, there are no recent subjective complaints or objective examination findings supporting a diagnosis of radiculopathy at the specifically proposed levels. Additionally, there are no imaging or electrodiagnostic studies corroborating the diagnosis of radiculopathy. Finally, it appears the current request is for a series of 2 injections. Guidelines do not support a series of injections. As such, the currently requested Bilateral L4-L5 transforaminal epidural steroid injection is not medically necessary.

