MAXIMUS Federal Services

Case Number:	CM15-0098150		
Date Assigned:	05/29/2015	Date of Injury:	10/04/2012
Decision Date:	06/30/2015	UR Denial Date:	05/02/2015
Priority:	Standard	Application Received:	05/21/2015

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: Georgia
Certification(s)/Specialty: Anesthesiology, 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 38 year old male who sustained an industrial injury on October 4, 2012. He has reported neck pain, lower back pain, and lower extremity pain and has been diagnosed with cervical radiculitis, chronic pain other, lumbar radiculopathy, right knee pain, and status post bilateral inguinal hernia repair. Treatment has included chiropractic care, acupuncture, surgery, medical imaging, medications, and injections. There was spinal vertebral tenderness was noted in the cervical spine C5-7. The range of motion was slightly to moderately limited. There was tenderness noted upon palpation in the spinal vertebral area L4-S1 levels. Range of motion was moderately limited secondary to pain. Tenderness was noted on palpation at the left shoulder. The range of motion was decreased due to pain. Tenderness was noted on palpation at the right knee. The treatment request included an epidural steroid injection, tramadol, and nortriptyline.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical interlaminar epidural steroid injection using fluoroscopy on the left at C5-6:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ESI.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 47.

Decision rationale: Cervical interlaminar epidural steroid injection using fluoroscopy on the left at C5-6 is not medically necessary. The California MTUS page 47 states "the purpose of epidural steroid injections 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 is no significant long-term functional benefit. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Initially unresponsive to conservative treatment, injections should be performed using fluoroscopy, if the ESI is for diagnostic purposes a maximum of 2 injections should be performed. No more than 2 nerve root levels should be injected using transforaminal blocks. No more than 1 interlaminar level should be injected at one session. 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 6-8 weeks, with the general recommendation of no more than 4 blocks per region per year. Current research does not support a series of 3 injections in either the diagnostic or therapeutic phase. We recommend no more than 2 epidural steroid injections". According to the notes the patient had prior injections without documented benefit of at least 50% reduction in pain for at least 6 weeks.

Unknown prescription of Tramadol 50 mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 83.

Decision rationale: Unknown prescription of Tramadol 50 mg is not medically necessary. Ultram is Tramadol. Tramadol is a centrally- acting opioid. Per MTUS page 83, opioids for osteoarthritis are recommended for short-term use after failure of first line non-pharmacologic and medication option including Acetaminophen and NSAIDS. Additionally, Page 79 of MTUS guidelines states that weaning of opioids are recommended if (a) there are no overall improvement in function, unless there are extenuating circumstances (b) continuing pain with evidence of intolerable adverse effects (c) decrease in functioning (d) resolution of pain (e) if serious non-adherence is occurring (f) the patient requests discontinuing. The claimant's medical records did not document that there was an overall improvement in function or a return to work with previous opioid therapy. In fact, the claimant continued to report pain. Given Tramadol is a synthetic opioid, its use in this case is not medically necessary. The claimant has long-term use with this medication and there was a lack of improved function or return to work with this opioid and all other medications.

Nortriptyline HCL 25 mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-depressants Page(s): 13-14.

Decision rationale: Nortriptyline HCL 25 mg #30 is not medically necessary. Ca MTUS page 13-14 states that antidepressants for chronic pain as recommended as first-line option for neuropathic pain and as a possibility for non-neuropathic pain. Tricyclics are generally considered first line agent unless they are ineffective, poorly tolerated, or contraindicated. Analgesia generally occurs within a few days to a week, whereas antidepressants effects take longer to occur. Assessment of treatment efficacy should include not only pain outcomes but also in evaluation of function, changes in the use of other analgesic medication, sleep quality and duration, and psychological assessment. Side effects include excessive sedation (Additional side effects are listed below for each specific drug.) It is recommended that these outcome measurements should be initiated at one week of treatment with a recommended trial of at least 4 weeks. The optimal duration of treatment is not known because most double-blind trials have been of short duration (6-12 weeks). It has been suggested that if pain is in remission for 3-6 months, a gradual tapering of anti-depressants may be undertaken. (Perrot, 2006) (Schnitzer, 2004) (Lin-JAMA, 2003) (Salerno, 2002) (Moulin, 2001) (Fishbain, 2000) (Taylor, 2004) (Gijsman, 2004) (Jick-JAMA, 2004) (Barbui, 2004) (Asnis, 2004) (Stein, 2003) (Pollack, 2003) (Ticknor, 2004) (Staiger, 2003) Long-term effectiveness of anti-depressants has not been established. (Wong, 2007) The effect of this class of medication in combination with other classes of drugs has not been well researched. The medical records did not document treatment efficacy including pain outcome, function, changes in medication, sleep quality and duration or even provide a true psychological assessment. Given the lack of positive response to the medication as the patient continued to display psychogenic pain as well as permanent disability, the requested medication is not medically necessary.