

Case Number:	CM15-0099708		
Date Assigned:	06/02/2015	Date of Injury:	09/16/2004
Decision Date:	08/06/2015	UR Denial Date:	04/29/2015
Priority:	Standard	Application Received:	05/22/2015

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, Texas, Florida

Certification(s)/Specialty: Anesthesiology, Pain Management, Hospice & Palliative Medicine

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 65 year old female, who sustained an industrial injury on September 16, 2004 while working as a head custodian. The injury occurred when the injured worker lifted a trash container and experienced a "snap" in the left lower back. The diagnoses have included degeneration of lumbar or lumbosacral intervertebral disc, lumbar radiculitis, thoracic of lumbosacral neuritis or radiculitis unspecified, pain in joint multiple sites, myalgia and myositis unspecified, spasm of muscle, long-term use of other medications and myasthenia gravis. Treatment to date has included medications, radiological studies, MRI, electrodiagnostic studies, H-Wave unit, epidural steroid injections, nerve root block, physical therapy, ice treatments and lumbar surgery. Current documentation dated April 15, 2015 notes that the injured worker reported low back pain, which was noted to be unchanged or worse. Examination of the lumbar spine revealed tenderness and a limited range of motion due to pain. A straight leg raise test was positive on the right. The documentation notes that the injured worker was benefiting from opiate therapy. The treating physician's plan of care included requests for Percocet 10/325 mg # 25 and a right lumbar five transforaminal epidural steroid injection with fluoroscopic guidance and sedation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325mg quantity 25: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter, Opioids for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): (s) 44, 47, 75-79 and 120.

Decision rationale: Regarding the request for Percocet (oxycodone/acetaminophen), California Pain Medical Treatment Guidelines state that Percocet 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 or pain (in terms of specific examples of functional improvement and percent reduction in pain or reduced NRS). 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 Percocet (oxycodone/acetaminophen) is not medically necessary.

Right L5 Transforaminal Epidural Steroid Injection with Fluoroscopic Guidance and Sedation: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections.

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

Decision rationale: The MTUS, chronic pain section, page 46 describes the criteria for epidural steroid injections. Epidural injections are a possible option when there is radicular pain caused by a radiculopathy documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. This injured worker does not meet the MTUS criteria for an epidural steroid injection at the right L5 location. There are insufficient clinical findings of radiculopathy, such as dermatomal sensory loss or motor deficits correlating with a specific lesion identified by objective testing. No right sided radicular pain was described. The MRI and electrodiagnostic testing did not show a specific lesion causing a right sided radiculopathy. This right-sided epidural injection is not medically necessary based on the MTUS indications which are not met in this case.