

<b>Case Number:</b>	CM14-0152650		
<b>Date Assigned:</b>	09/22/2014	<b>Date of Injury:</b>	01/08/2010
<b>Decision Date:</b>	11/03/2014	<b>UR Denial Date:</b>	09/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/18/2014

### 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. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 56 year-old female with date of injury 01/08/2010. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 08/22/2014, lists subjective complaints as pain in the low back. Objective findings: Examination of the lumbar spine revealed diffuse tenderness over the lumbosacral region. Lumbar flexion was limited to 45 degrees, extension limited on return to neutral, and rotation elicited pain and was limited to 30 degrees bilaterally. Dysesthesia of the left posterior leg into the calf, and dysesthesia of the entire right foot. Motor function was 3+/5 on the left lower extremity due to pain and weakness, and normal 5/5 on the right. Diagnoses are post-laminectomy syndrome of lumbar region; degeneration of lumbosacral intervertebral disc; other symptoms referable to back; displacement of lumbar intervertebral disc without myelopathy; chronic pain syndrome; dysesthesia; and lumbar facet joint pain. The medical records supplied for review document that the patient has been taking the following medications for at least as far back as 7 months. Medications include Tramadol 50mg, #180 SIG: 1-2 three times a day and Norco 10/325mg, #180 SIG: 1 tablet every 4 hours.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Tramadol 50mg #180:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Ultram Page(s): 91, 93-94, 78-80.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 113.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines state that continued or long-term use of opioids should be based on documented pain relief and functional improvement or improved quality of life. Tramadol is a centrally acting synthetic opioid analgesic and it is not recommended as a first-line oral analgesic. The patient is reporting minimal improvement in pain with no evidence of functional improvement. There is no documentation supporting the continued long-term use of opioids. Therefore, this request is not medically necessary.

**Norco 10/325mg #180:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 124.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-94.

**Decision rationale:** A previous utilization review decision provided the patient with sufficient quantity of medication to be weaned slowly off of narcotic. The Chronic Pain Medical Treatment Guidelines state that continued or long-term use of opioids should be based on documented pain relief and functional improvement or improved quality of life. Despite the long-term use of narcotics, the patient has reported very little, if any, functional improvement or pain relief over the course of the last 7 months. Therefore, this request is not medically necessary.

**Epidural Steroid Injection (ESI):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection Page(s): 46.

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

**Decision rationale:** According to the MTUS, several diagnostic criteria must be present to recommend an epidural steroid injection. The most important criteria are that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 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. The request is for a repeat epidural steroid injection, but the medical record states that the patient's previous LESI provided very little relief. An epidural steroid injection is not medically necessary.