

<b>Case Number:</b>	CM14-0020470		
<b>Date Assigned:</b>	04/30/2014	<b>Date of Injury:</b>	03/07/2003
<b>Decision Date:</b>	07/08/2014	<b>UR Denial Date:</b>	02/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/19/2014

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a Physician Reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The Physician Reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Management, 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 Physician 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 an employee of [REDACTED] and has submitted a claim for cervical post laminectomy syndrome associated with an industrial injury date of March 7, 2003. Treatment to date has included oral analgesics, muscle relaxants, cervical and lumbar surgeries, lumbosacral binder, physical therapy, and bone stimulator. Medical records from 2013 to 2014 were reviewed and showed low back pain and radicular symptoms into both lower extremities. Physical examination of the cervical spine showed limitation of motion and tenderness over the posterior cervical musculature, trapezius, medial scapular and suboccipital region with multiple taut bands. Examination of the lumbar spine revealed limitation of motion, tenderness in the lumbar paravertebral musculature and sciatic notch region, trigger points, and taut bands. Other physical examination findings include decreased lower extremity reflexes; decreased motor strength in the L5 and S1 myotomes bilaterally; decreased sensation along the posterior lateral thigh, lateral calf and dorsum of the foot in the L5-S1 distribution; and positive straight leg raise in the modified sitting position at 45 degrees. There is a very stiff antalgic and unsteady gait. EMG testing of the upper and lower extremities revealed severe bilateral C4, C5, L2 and L5 radiculopathy as well as bilateral C7 radiculopathy. Treating diagnoses include status post C5-6 and C6-7 ACDF x 2 with residual bilateral upper extremity radiculopathy and cervicogenic headaches becoming migrainous in nature, lumbar post laminectomy syndrome status post L3-4, L4-5, and L5-S1 posterior lumbar interbody fusion with revision x4 with residual bilateral lower extremity radiculopathies, bilateral shoulder rotator cuff tears and internal derangement status post left arthroscopic rotator cuff, bilateral knee internal derangement, right greater than the left; medication-induced gastritis, coronary disease status post myocardial infarction, non-insulin dependent diabetes, and reactionary depression/anxiety. It was recommended that the patient undergo a transforaminal ESI at the bilateral S1 to reduce pain and inflammation and help restore range of motion and more active treatment programs to avoid surgery. The patient has been unresponsive to conservative treatment with physical therapy, time and medical management. The

patient has been taking Norco as far back as 2012 with noted increase in intake on December 2013 from 5 tablets daily to 8 tablets daily to relieve pain. Utilization review dated February 13, 2014 denied the request for four (4) trigger point injections for a total of 10cc of 0.25% bupivacaine DOS 1/17/14 because physical examination findings were consistent with radiculopathy which is an exclusionary criterion. The request for fluoroscopy-guided diagnostic transforaminal epidural steroid injection at bilateral S1, 2 diagnostic injections 2 weeks apart was modified to bilateral S1 TESI x one (1) because trial treatment to provide pain relief and improve function is recommended by the guideline. The request for Norco 10/325mg #240 was modified to Norco 10/325mg #120 to allow tapering because there is no documentation of the results of previous urine drug screen.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **FLUOROSCOPY GUIDED DIAGNOSTIC TRANSFORAMINAL EPIDURAL STEROID INJECTION AT BILATERAL 21 - TWO (2) DIAGNOSTIC INJECTIONS TWO (2) WEEKS APART: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines EPIDURAL STEROID INJECTIONS Page(s): 46.

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

**Decision rationale:** Page 46 of the California MTUS Chronic Pain Medical Treatment Guidelines indicates that epidural steroid injection (ESI) is an option for treatment of radicular pain. Most current guidelines recommend no more than two epidural steroid injections. 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. In this case, physical examination findings show neurologic deficits in the L5 and S1 myotomes bilaterally for which 2 diagnostic lumbar ESI were requested. However, the guidelines only allow a second block when there is an inadequate response to the first one. Therefore, the request for fluoroscopy guided diagnostic transforaminal epidural steroid injection at bilateral S1 – two (2) diagnostic injections two (2) weeks apart is not medically necessary.

**NORCO 10/325MG #240: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS Page(s): 79-81.

**Decision rationale:** Pages 79-81 of the California MTUS Chronic Pain Medical Treatment Guidelines indicate that ongoing opioid treatment is not supported unless prescribed at the lowest possible dose and unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In this case, the employee was being prescribed with Norco since 2012. However, a progress report on December 2013 showed increase in intake from 5 tablets to 8 tablets daily to relieve pain. The guidelines support continued opioid intake if there is continued analgesia. Moreover, there was no documentation of functional benefit with its use; and previous urine drug screen results to show monitoring and employee compliance were not provided. The criteria for continued opioid treatment was not met. Therefore, the request for NORCO 10/325MG #240 is not medically necessary.

**FOUR (4) TRIGGER-POINT INJECTIONS FOR A TOTAL OF 10CC OF 0.25% BUPIVACAINE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TRIGGER POINT INJECTIONS.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TRIGGER POINT INJECTIONS Page(s): 122.

**Decision rationale:** Page 122 of the California MTUS Chronic Pain Medical Treatment Guidelines indicates that criteria for trigger point injections include chronic low back or neck pain with myofascial pain syndrome with circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain; symptoms for more than three months; medical management therapies have failed; radiculopathy is not present; and no more than 3-4 injections per session. In this case, there were trigger points present at the lumbar spine; however lumbar radiculopathy was already an established diagnosis since the employee is presenting with back pain radiating to both lower extremities corroborated by physical examination finding of focal neurologic deficits. Trigger point injections are not supported if radiculopathy is present. The guideline criteria were not met. Therefore, the request for four (4) trigger point injections for a total of 10cc of 0.25% bupivacaine is not medically necessary.