

Case Number:	CM14-0187324		
Date Assigned:	11/17/2014	Date of Injury:	06/02/2000
Decision Date:	04/21/2015	UR Denial Date:	10/07/2014
Priority:	Standard	Application Received:	11/10/2014

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. 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: Massachusetts

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 66 year old male, who sustained an industrial injury on 6/2/2000. The mechanism of injury was not provided for review. The injured worker was diagnosed as having lumbar radiculopathy, lumbar facet arthropathy and sacroiliac joint dysfunction. There is no record of a recent radiology study. Treatment to date has included physical therapy, injections and medication management. Currently, the injured worker complains of right sided low back pain with improved right lower extremity radicular symptoms. In a progress note dated 9/19/2014, the treating physician is requesting Percocet, Toxicology screen and a right lumbar 5-sacral 1 epidural steroid injection with anesthesia.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 10/325mg #60: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (1) Pain Outcomes and Endpoints, p8, (2) Opioids, criteria for use, p76-80 (3) Opioids, dosing, p86 Page(s): 8, 76-80, 86.

Decision rationale: The claimant is nearly 15 years status post work-related injury and continues to be treated for chronic low back pain with right lower extremity radicular symptoms. An MRI of the lumbar spine included findings of mild to moderate L4-5 canal and foraminal stenosis. EMG/NCS testing had shown findings of radiculopathy. When seen by the requesting provider he was having low back pain and right lower extremity radicular pain. Physical examination findings included positive straight leg raising with decreased right lower extremity sensation and the claimant was noted to be limping. Medications include Percocet. Percocet (oxycodone/acetaminophen) is a short acting combination opioid often used for intermittent or breakthrough pain. In this case, it is being prescribed as part of the claimant's ongoing management. There are no identified issues of abuse, addiction, or poor pain control. There are no inconsistencies in the history, presentation, the claimant's behaviors, or by physical examination. The total MED is less than 120 mg per day consistent with guideline recommendations. Therefore, the continued prescribing of Percocet was medically necessary.

Tox Screen: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines drug testing. Decision based on Non-MTUS Citation ODG- TWC Pain Procedure Summary last updated 10/02/2014; regarding Urine Drug Testing (UDT).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (1) Pain (Chronic): Opioids, screening tests for risk of addiction & misuse (2) Pain (Chronic): Urine drug testing (UDT).

Decision rationale: The claimant is nearly 15 years status post work-related injury and continues to be treated for chronic low back pain with right lower extremity radicular symptoms. Medications include Percocet being prescribed on a long-term basis. Criteria for the frequency of urine drug testing include documented evidence of risk stratification including use of a testing instrument. Patients at 'low risk' of addiction/aberrant behavior should be tested within six months of initiation of therapy and on a yearly basis thereafter. In this case, the claimant would be considered at low risk. There are no urine drug test results within year prior to this request. In this case, the testing requested was within guideline recommendations and therefore was medically necessary.

Right L5- S1 Transforaminal ESI Anesthesia with X-ray under Fluoroscopic Guidance:
Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of epidural steroid injections. Decision based on Non-MTUS Citation ODG- TWC Pain Procedure Summary last updated 08/22/2014 regarding; Epidural steroid injections.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of Epidural steroid injections, p46 Page(s): 46.

Decision rationale: The claimant is nearly 15 years status post work-related injury and continues to be treated for chronic low back pain with right lower extremity radicular symptoms. An MRI of the lumbar spine included findings of mild to moderate L4-5 canal and foraminal stenosis. EMG/NCS testing had shown findings of radiculopathy. When seen by the requesting provider he was having low back pain and right lower extremity radicular pain. Physical examination findings included positive straight leg raising with decreased right lower extremity sensation and the claimant was noted to be limping. Criteria for the use of epidural steroid injections include that radiculopathy be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. In this case, the claimant's provider documents decreased lower extremity sensation with positive neural tension signs and imaging and MRI and EMG/NCS tests have shown findings consistent with the presence of radiculopathy. Prior conservative treatments have included physical therapy and medications. This request is for an epidural steroid injection to be performed under fluoroscopy. The criteria are met and the requested epidural steroid injection is therefore considered medically necessary.