

Case Number:	CM14-0097438		
Date Assigned:	11/18/2014	Date of Injury:	11/08/1999
Decision Date:	01/06/2015	UR Denial Date:	06/25/2014
Priority:	Standard	Application Received:	06/25/2014

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 Family 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:

This 47 year-old female reportedly sustained an industrial related injury on November 8, 1999 resulting in injury to neck, low back, right hip, abdomen and right lower leg. Diagnoses include cervicalgia; post laminectomy syndrome lumbar region, joint pain multiple sites, trochanteric bursitis, history of deep venous thrombosis (DVT), right foot drop, unspecified myalgia and myositis. Her primary care physician documents the injured worker has post-surgical complications of severe low back pain, right drop foot, legs giving way, neurological issues and lower extremity edema related to failed back surgery syndrome. Pain consistently is rated 10/10 without medication and is 4/10 with medication. Office visit on December 31, 2013 pain is 6/10. On February 3, 2014 the record documents successful caudal epidural steroid injection (ESI) without complications noted. Her primary care physician for the same date noted the injured worker to be in no distress, to have no lower extremity deep tendon reflex on right, only trace on left and very limited range of motion (ROM) of the neck. Pain remained 10/10 without medication and was noted as 6/10 the day of visit. The office visit on March 11, 2014 notes caudal epidural steroid injection (ESI) on February 3, 2014 resulted in 50% pain reduction and pain rated as 8/10. The primary care visit dated May 21, 2014 documents that her chronic pain continues and that caudal epidural steroid injection (ESI) on February 3, 2014 resulted in greater than 60% pain reduction for more than 6 weeks but that the pain is returned. Medication therapy provides for increased mobility, tolerance of activities of daily living (ADLs) and home physical therapy exercises. Pain the day of visit was rated as 7/10. The injured worker reports decrease in cognitive side effects related to stopping Effexor and Lexapro but an increase in nerve pain. The documentation provides the injured worker has a Transcutaneous Electrical Nerve Stimulation (TENS) unit and physical therapy but does not report effectiveness. Work status is permanent and stationary with fair prognosis. On June 25, 2014 Utilization Review determined a request

dated June 6, 2014 for repeat caudal epidural steroid injection (ESI) and urine drug test for medication monitoring to be non-certified. Application for independent medical review is dated June 6, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Repeat caudal ESI: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection (ESI).

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

Decision rationale: The MTUS/Chronic Pain Medical Treatment Guidelines comment on the use of Epidural Steroid Injections (ESIs). ESIs are recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). Most current guidelines recommend no more than 2 ESI injections. This is in contradiction to previous generally cited recommendations for a "series of three" ESIs. These early recommendations were primarily based on anecdotal evidence. Research has now shown that, on average, less than two injections are required for a successful ESI outcome. Current recommendations suggest a second epidural injection if partial success is produced with the first injection and a third ESI is rarely recommended. Epidural steroid injection can offer short-term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. There is little information on improved function. The American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular lumbosacral pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months, and there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain. The MTUS Guidelines also provide the specific criteria for the use of ESIs. These criteria include: Criteria for the use of Epidural steroid injections: 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). 3) Injections should be performed using fluoroscopy (live x-ray) for guidance. 4) 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. 5) No more than two nerve root levels should be injected using transforaminal blocks. 6) No more than one interlaminar level should be injected at one session. 7) 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. Current research does not support "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections. In this case the patient had an ESI in February, 2014 and a second approved ESI in

May, 2014. The results of the second ESI are not provided for review. This requested ESI would represent the 3rd ESI injection, which is not supported by the above stated guidelines. Therefore, a third caudal ESI injection is not considered as medically necessary.

Urine toxicology screening: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Urine drug screening

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug Testing Page(s): 43.

Decision rationale: The MTUS/Chronic Pain Medical Treatment Guidelines comment on the use of drug testing. These guidelines state that drug testing is recommended as an option, using a urine drug screen to assess for the use or the presence of illegal drugs. In addition, the guidelines comment on the steps used to avoid misuse/addiction of opioids. These steps include the use of frequent random urine toxicology screens. Based on the information in the available medical records the patient had a recent urine drug testing in May, 2014. The results of this testing was not provided in the records. Further, there is no documentation to suggest that the patient has engaged in any suspicious or aberrant behaviors to indicate that she is at high-risk for addiction. In summary, there is no evidence in the medical records to support the rationale for ordering a repeat urine drug screen. This test is not considered as medically necessary.