

<b>Case Number:</b>	CM15-0137984		
<b>Date Assigned:</b>	07/27/2015	<b>Date of Injury:</b>	02/23/2013
<b>Decision Date:</b>	08/24/2015	<b>UR Denial Date:</b>	06/19/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/16/2015

### 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  
 Certification(s)/Specialty: Emergency 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 36 year old male, who sustained an industrial injury on 2/23/13. He has reported initial complaints of left shoulder, right elbow and a back injury after a slip and fall accident at work. The diagnoses have included lumbago, chronic low back pain, lumbar radiculopathy, chronic left shoulder pain; status post left shoulder surgery, left shoulder labral tear with positive impingement, and history of back problems with multiple surgeries. Treatment to date has included medications, activity modifications, diagnostics, injections, surgery, physical therapy, home exercise program (HEP) and other modalities. As per the physician progress note dated 1/5/15, the injured worker complains of low back pain and left shoulder pain status post left shoulder surgery 8/2014 and low back surgery 3/11/14. He reports that the pain has worsened and rates the pain 8/10 on pain scale. The current medications are not listed. The urine drug screen dated 2/18/15 was inconsistent with the medications prescribed. The diagnostics that were noted to be completed included X-rays of the lumbar spine, Magnetic Resonance Imaging (MRI) of the lumbar spine, computerized axial tomography (CT scan) myelogram of the lumbar spine, Magnetic Resonance Imaging (MRI) of the left shoulder and X-rays of the left shoulder. There are no previous diagnostic reports noted in the records. The objective findings reveal positive left shoulder and lumbar tenderness and lumbosacral spine range of motion is decreased by 30 percent. The physician requested treatments included Bilateral S1 Transforaminal Epidural Steroid Injections (x2) and Norco 10/325mg #240, as prescribed on 06/16/15.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Bilateral S1 Transforaminal Epidural Steroid Injections (x2): Upheld**

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

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

**Decision rationale:** The requested Bilateral S1 Transforaminal Epidural Steroid Injections (x2) is not medically necessary. California's Division of Worker s Compensation Medical Treatment Utilization Schedule (MTUS), Chronic Pain Medical Treatment Guidelines, Pg. 46, Epidural steroid injections (ESIs), recommend an epidural injection with documentation of persistent radicular pain and physical exam and diagnostic study confirmation of Radiculopathy, after failed therapy trials. The injured worker has low back pain. The treating physician has documented positive left shoulder and lumbar tenderness and lumbosacral spine range of motion is decreased by 30 percent. The treating physician has not documented physical exam evidence indicative of Radiculopathy such as deficits in dermatomal sensation, reflexes or muscle strength; nor positive imaging and/or electro diagnostic findings indicative of Radiculopathy. The criteria noted above not having been met, Bilateral S1 Transforaminal Epidural Steroid Injections (x2) is not medically necessary.

### **Norco 10/325mg #240, as prescribed on 06/16/15: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, specific drug list, Hydrocodone/Acetaminophen; Opioids, criteria for use Page(s): 78- 80, 91, 124.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management, Pages 78-80, Opioids for Chronic Pain, Pages 80-82 Page(s): 78-82.

**Decision rationale:** The requested Norco 10/325mg #240, as prescribed on 06/16/15, is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Opioids, On-Going Management, Pages 78-80, Opioids for Chronic Pain, Pages 80-82, recommend continued use of this opiate for the treatment of moderate to severe pain, with documented objective evidence of derived functional benefit, as well as documented opiate surveillance measures. The injured worker has low back pain. The treating physician has documented positive left shoulder and lumbar tenderness and lumbosacral spine range of motion is decreased by 30 percent. The treating physician has not documented VAS pain quantification with and without medications, duration of treatment, objective evidence of derived functional benefit such as improvements in activities of daily living or reduced work restrictions or decreased reliance on medical intervention, nor measures of opiate surveillance including an executed narcotic pain contract or urine drug screening. The criteria noted above not having been met, Norco 10/325mg #240, as prescribed on 06/16/15 is not medically necessary.

