

Case Number:	CM15-0188403		
Date Assigned:	09/30/2015	Date of Injury:	03/31/2006
Decision Date:	11/13/2015	UR Denial Date:	08/24/2015
Priority:	Standard	Application Received:	09/24/2015

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, District of Columbia, Maryland
 Certification(s)/Specialty: Anesthesiology, 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 47 year old female, who sustained an industrial injury on 3-31-2006. The injured worker was being treated for cervicalgia, status post lumbar spine laminectomy with residual pain, lumbar radiculopathy, post-traumatic stress disorder (PTSD), and thoracic or lumbosacral neuritis or radiculitis not otherwise specified. Medical records (5-19-2015 to 7-21-2015) indicate the injured worker reported ongoing burning, radicular neck pain and muscle spasms. In addition, she reported ongoing residual pain and burning sensation status post lumbar laminectomy. Associated symptoms included radiating pain, numbness, and tingling of the bilateral lower extremities, left greater than right. The medical record show the subjective pain rating shows no significant improvement from neck: 6 out of 10 and back: 7-8 out of 10 on 5-19-2015 to neck: 5 out of 10 and back: 6-7 out of 10 on 7-21-2015. The physical exam (5-19-2015 to 7-21-2015) revealed increased cervical and lumbar range of motion and tenderness to palpation at the cervical paraspinal, trapezius, and scalene muscles. There was a trigger point at the right levator scapula. There was a well-healed midline lumbar spine incision, ability to heel-toe walk, and pain with heel walking, greater on the left. There was tenderness to palpation at the bilateral posterior superior iliac spines, greater on the left, and at the lumbar paraspinal muscles. There was decreased strength in all of the represented muscle groups of the bilateral upper and lower extremities. There was decreased sensation over the C5-T1 (cervical 5-thoracic 1) dermatomes in the upper extremities and slightly decreased sensation at the bilateral L4-S1 (lumbar 4-sacral 1) dermatomes of the bilateral lower extremities. On 6-25-2015, an MRI of the lumbar spine revealed a 5 millimeter broad-based right subarticular disc protrusion with

associated annular fissure and mild facet arthropathy causing severe subarticular stenosis with mass effect upon the traversing right L4 (lumbar 4) nerve root. There was mild to moderate central canal stenosis. At L4-5, there was a 4 millimeter broad-based posterior disc protrusion and moderate arthropathy causing moderate bilateral subarticular recess narrowing and moderate right and mild left neuroforaminal narrowing. There was mild central canal stenosis. At L5-S1 (lumbar 5-sacral 1), there was an 8 focal central disc protrusion extending in the caudal direction and moderate to severe facet arthropathy causing moderate bilateral subarticular recess narrowing, neuroforaminal narrowing, and central canal stenosis. Surgeries to date have included a lumbar laminectomy in 2006. Treatment has included physical therapy, acupuncture, psychotherapy, cognitive behavioral therapy, epidural steroid injections, and medications including pain (Hydrocodone), muscle relaxant (Tabradol), anti-epilepsy (Fanatrex), antidepressant (Prozac and Trazadone), histamine 2 antagonist (Deprizine), sleep (Ambien, Dicopanol), and non-steroidal anti-inflammatory (Synapryn). On 7-28-2015, the requested treatments included a caudal epidural steroid injection and Tylenol #4, Qty 60. On 8-25-2015, the original utilization review non-certified requests for a caudal epidural steroid injection and Tylenol #4, Qty 60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Caudal epidural steroid injection: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

Decision rationale: Per the MTUS CPMTG epidural steroid injections are used to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs and avoiding surgery, but this treatment alone offers no significant long-term benefit. The criteria for the use of epidural steroid injections are as follows: 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. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007) 8) Current research does not support a series-of-three injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections. Per the medical records submitted for review, there was decreased strength noted

in all the represented muscle groups of the bilateral upper and lower extremities. There was decreased sensation over the C5-T1 dermatomes and slightly decreased sensation at the bilateral L4-S1 dermatomes of the bilateral lower extremities. MRI of the lumbar spine dated 6/25/15 revealed at L5-S1 a central disc protrusion extending in the caudal direction and moderate to severe facet arthropathy causing moderate bilateral subarticular recess narrowing, neuroforaminal narrowing, and central canal stenosis. It was noted that the injured worker was previously treated with caudal epidural steroid injections, however, there was no documentation of at least 50% pain relief with associated reduction of medication use for six to eight weeks. Absent such documentation, the medical necessity of repeat injection cannot be affirmed.

Tylenol #4, Qty 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

Decision rationale: Per MTUS Chronic Pain Medical Treatment Guidelines p78 regarding ongoing management of opioids "Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: Pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug related behaviors. These domains have been summarized as the 4 A's (Analgesia, activities of daily living, adverse side effects, and any aberrant drug-taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs." Review of the available medical records reveals insufficient documentation to support the medical necessity of Tylenol #4 nor sufficient documentation addressing the '4 A's' domains, which is a recommended practice for the on-going management of opioids. Specifically, the notes do not appropriately review and document functional status improvement, appropriate medication use, or side effects. The MTUS considers this list of criteria for initiation and continuation of opioids in the context of efficacy required to substantiate medical necessity, and they do not appear to have been addressed by the treating physician in the documentation available for review. Per the medical records, the injured worker rated her pain 8/10 without medications and 6-7/10 with medications. Efforts to rule out aberrant behavior (e.g. CURES report, UDS, opiate agreement) are necessary to assure safe usage and establish medical necessity. There is no documentation comprehensively addressing this concern in the records available for my review. As MTUS recommends to discontinue opioids if there is no overall improvement in function, medical necessity cannot be affirmed.