

<b>Case Number:</b>	CM15-0194088		
<b>Date Assigned:</b>	10/07/2015	<b>Date of Injury:</b>	01/05/2006
<b>Decision Date:</b>	11/19/2015	<b>UR Denial Date:</b>	09/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/02/2015

### 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 37 year old male, who sustained an industrial injury on 1-5-06. He reported low back pain. The injured worker was diagnosed as having lumbago, sciatica, and lumbar radicular syndrome. Treatment to date has included medication such as Ibuprofen, Flexeril, and Tramadol. Physical examination findings on 9-2-15 included restricted lumbar spine range of motion and a positive left straight leg raise test. Motor strength was rated as 5 of 5 in all muscle groups. A MRI of the lumbar spine obtained on 8-20-15 revealed L5-S1 disc protrusions with lateral recess stenosis and compression and mild posterior displacement of the left S1 root. L4-5 mild effacement of the thecal sac with central or paracentral protrusion and annular tear was also noted. On 9-2-15, the injured worker complained of lumbar spine pain with radiation to the left lower extremity. The treating physician requested authorization for a caudal lumbar epidural steroid injection, a CBC, and urinalysis. On 9-15-15 the requests were non- certified.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Caudal LESI (x1): Upheld**

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

**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. MRI of the lumbar spine revealed lateral recess stenosis with compression and mild posterior displacement of left S1 root. Right lateral recess stenosis secondary to disc protrusion contacts the right S1 root. Physical exam dated 8/25/15 noted motor strength 5/5 in all muscle groups, Sensation intact, DTR absent at left ankle, 2+ at right ankle and both knees. Above mentioned citation conveys radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Radiculopathy is defined as two of the following: weakness, sensation deficit, or diminished/absent reflexes associated with the relevant dermatome. These findings are not documented, so medical necessity is not affirmed. As the first criteria is not met, the request is not medically necessary.

**Complete blood count (CBC):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, (<http://www.odg-twc.com/odgtwc/knee.htm>).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Preoperative Lab Testing.

**Decision rationale:** Per ODG TWC, "preoperative lab testing should be guided by the patient's clinical history, comorbidities, and physical examination findings. Preoperative routine tests are appropriate if patients with abnormal tests will have a preoperative modified approach (i.e., new tests ordered, referral to a specialist or surgery postponement). Testing should generally be done to confirm a clinical impression, and tests should affect the course of treatment." Criteria for Preoperative lab testing:- Preoperative urinalysis is recommended for patients undergoing invasive urologic procedures and those undergoing implantation of foreign material. Electrolyte and creatinine testing should be performed in patients with underlying chronic disease and those taking medications that predispose them to electrolyte abnormalities or renal failure. Random glucose testing should be performed in patients at high risk of undiagnosed diabetes mellitus. In patients with diagnosed diabetes, A1C testing is recommended only if the result would change

perioperative management. A complete blood count is indicated for patients with diseases that increase the risk of anemia or patients in whom significant perioperative blood loss is anticipated. Coagulation studies are reserved for patients with a history of bleeding or medical conditions that predispose them to bleeding, and for those taking anticoagulants. The documentation provided for review does not indicate that the injured worker has any comorbidity that necessitates preoperative labs. Furthermore, the requested epidural injection was not medically necessary. This request is not medically necessary.

**Urinalysis (UA):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, (<http://www.odg-twc.com/odgtwc/knee.htm>).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids (Classification).

**Decision rationale:** MTUS Chronic Pain guidelines recommend random drug screening for patients to avoid the misuse of opioids, particularly for those at high risk of abuse. Upon review of the submitted medical records, the injured worker is not a high risk for abuse. Per MTUS CPMTG p87, "Indicators and predictors of possible misuse of controlled substances and/or addiction: 1) Adverse consequences: (a) Decreased functioning, (b) Observed intoxication, (c) Negative affective state 2) Impaired control over medication use: (a) Failure to bring in unused medications, (b) Dose escalation without approval of the prescribing doctor, (c) Requests for early prescription refills, (d) Reports of lost or stolen prescriptions, (e) Unscheduled clinic appointments in "distress", (f) Frequent visits to the ED, (g) Family reports of overuse of intoxication, 3) Craving and preoccupation: (a) Non-compliance with other treatment modalities, (b) Failure to keep appointments, (c) No interest in rehabilitation, only in symptom control, (d) No relief of pain or improved function with opioid therapy, (e) Overwhelming focus on opiate issues. 4) Adverse behavior: (a) Selling prescription drugs, (b) Forging prescriptions, (c) Stealing drugs, (d) Using prescription drugs in ways other than prescribed (such as injecting oral formulations), (e) Concurrent use of alcohol or other illicit drugs (as detected on urine screens), (f) Obtaining prescription drugs from non-medical sources."As the requested epidural steroid injection is not medically necessary, preoperative UA is not medically necessary.