

Case Number:	CM15-0088304		
Date Assigned:	05/12/2015	Date of Injury:	12/07/2009
Decision Date:	06/18/2015	UR Denial Date:	04/09/2015
Priority:	Standard	Application Received:	05/07/2015

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: Florida
 Certification(s)/Specialty: Family Practice

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 39 year old male, who sustained an industrial injury on December 7, 2009. He reported right sided low back pain radiating to the right lower extremity. The injured worker was diagnosed as having status post PSIF, laminectomy and foraminotomy of the lumbar spine, lumbar neural foraminal stenosis with radiculopathy, status post anterior and posterior fusion and laminotomy of the lumbar spine in 2013, laminotomy of the lumbar spine in 2009, seizure versus vasovagal episode and status post fall resulting in lumbar 4 fracture. Treatment to date has included diagnostic studies, radiographic imaging, multiple surgical interventions of the lumbar spine, conservative care, medications and work restrictions. Currently, the injured worker complains of continued right sided low back pain with right lower extremity radicular symptoms. The injured worker reported an industrial injury in 2009, resulting in the above noted pain. He was treated conservatively and surgically without complete resolution of the pain. Evaluation on April 21, 2105, revealed continued pain as noted. Radiographic imaging revealed progressive signs of fusion, no signs of lucency or fractures, posterior hardware intact and no adjacent segment degeneration. Bilateral injections to the lumbar spine and medications were requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Oxycontin 20 mg Qty 90: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of opioids, page(s) 76-80 Page(s): 76-80.

Decision rationale: In accordance with California MTUS guidelines, narcotics for chronic pain management should be continued if; "(a) If the patient has returned to work, (b) If the patient has improved functioning and pain." MTUS guidelines also recommend that narcotic medications only be prescribed for chronic pain when there is evidence of a pain management contract being upheld with proof of frequent urine drug screens. Regarding this patient's case, there is no objective evidence of functional improvement. Therefore, this request is not medically necessary.

Percocet 10/325 mg Qty 60: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of opioids, page(s) 76-80 Page(s): Criteria for use of opioids, page(s) 76-80.

Decision rationale: In accordance with California MTUS guidelines, narcotics for chronic pain management should be continued if; "(a) If the patient has returned to work, (b) If the patient has improved functioning and pain." MTUS guidelines also recommend that narcotic medications only be prescribed for chronic pain when there is evidence of a pain management contract being upheld with proof of frequent urine drug screens. Regarding this patient's case, there is no objective evidence of functional improvement. Therefore, this request is not medically necessary.

Bilateral (lumbosacral) L5-S1, Transforaminal Epidural Steroid Injection: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: Criteria for the use of Epidural steroid injections: Note: The purpose of ESI is 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 functional benefit. "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. Regarding this patient's case, a Bilateral LESI is being requested. Utilization review approved a right L5-S1 ESI, but not the left side injection. The patient is noted to have pain that radiates into the right lower extremity, but no pain in the left lower extremity. Guidelines state that radiculopathy must be documented by physical exam and collaborated with imaging studies. In this case, there is no documented evidence of radiculopathy in the left lower extremity on physical exam. Therefore, MTUS guidelines have not been satisfied. Likewise, this request for a bilateral LESI is not medically necessary.