

<b>Case Number:</b>	CM15-0115101		
<b>Date Assigned:</b>	06/23/2015	<b>Date of Injury:</b>	10/21/1996
<b>Decision Date:</b>	07/22/2015	<b>UR Denial Date:</b>	06/04/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/15/2015

### 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: North Carolina  
 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 75-year-old female, who sustained an industrial/work injury on 10/21/96. She reported initial complaints of neck and arm pain. The injured worker was diagnosed as having cervical musculoligamentous injury, s/p cervical fusion with residual chronic pain. Treatment to date has included medication, epidural steroid injection, and psychology evaluation. Currently, the injured worker complains of progressive limited range of motion to the neck and arm pain with spasms and headache. There was weakness in the arms. Pain was rated 8/10 with flare up of 9/10. There was 80% improvement after the third epidural injection done February 2015. Per the primary physician's progress report (PR-2) on 5/13/15, examination revealed weakness in the arms, which are progressive with weak grip during writing or holding objects, frequent headaches with blurred vision that are severe in nature. Current plan of care included 4th epidural injection under fluoroscopy guidance. The requested treatments include CESI (cervical epidural steroid injection) #4 C7-T1 with Cath C3-C7, Dilaudid 8mg, and P Stim x 4.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CESI #4 C7-T1 with Cath C3-C7: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines epidural steroid injections.

**Decision rationale:** The California chronic pain medical treatment guidelines section on epidural steroid injections (ESI) states: 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 electro diagnostic 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. Previous ESI does not have documented relief lasting 6-8 weeks with documented medication reduction in usage. Therefore, the request is not medically necessary.

**Dilaudid 8mg #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines opioids  
Page(s): 76-84.

**Decision rationale:** The California chronic pain medical treatment guidelines section on opioids states for ongoing management: On-Going Management. Actions Should Include: (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy. (b) The lowest possible dose should be prescribed to improve pain and function. (c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: 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 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. (Passik, 2000)(d) Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain diary that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management. (e) Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control. (f) Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion). (g) Continuing review of overall situation with regard to non-opioid means of pain control. (h) Consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consult if there is evidence of substance misuse. When to Continue Opioids (a) If the patient has returned to work; (b) If the patient has improved functioning and pain. (Washington, 2002) (Colorado, 2002) (Ontario, 2000) (VA/DoD, 2003) (Maddox-AAPM/APS, 1997) (Wisconsin, 2004) (Warfield, 2004) The long-term use of this medication class is not recommended per the California MTUS unless there documented evidence of benefit with measurable outcome measures and improvement in function. There is no documented significant improvement in VAS scores for significant periods of time. There are no objective measurements of improvement in function. Therefore, all criteria for the ongoing use of opioids have not been met and the request is not medically necessary.

**P Stim x 4:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines PENS Page(s): 97.

**Decision rationale:** The California MTUS section on PENS states: Percutaneous electrical nerve stimulation (PENS): Not recommended as a primary treatment modality, but a trial may be considered, if used as an adjunct to a program of evidence-based functional restoration, after other non-surgical treatments, including therapeutic exercise and TENS, have been tried and failed or are judged to be unsuitable or contraindicated. There is a lack of high quality evidence to prove long-term efficacy. (Ghonaime-JAMA, 1999) (Yokoyama, 2004) Percutaneous electrical nerve stimulation (PENS) is similar in concept to transcutaneous electrical nerve stimulation (TENS) but differs in that needles are inserted to a depth of 1 to 4 cm either around or immediately adjacent to the nerve serving the painful area and then stimulated. PENS is generally reserved for patients who fail to get pain relief from TENS, apparently due to obvious physical barriers to the conduction of the electrical stimulation (e. g. , scar tissue, obesity). PENS must be distinguished from acupuncture with electrical stimulation. In PENS, the location of stimulation is determined by proximity to the pain. (BlueCross BlueShield, 2004) (Aetna, 2005) This RCT concluded that both PENS and therapeutic exercise for older adults with chronic low back pain significantly reduced pain. (Weiner, 2008) Criteria for use have not been met in the provided clinical documentation for review and therefore the request is not medically necessary.