

<b>Case Number:</b>	CM13-0068730		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	11/05/2012
<b>Decision Date:</b>	05/28/2014	<b>UR Denial Date:</b>	12/09/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/19/2013

### 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. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

Treatment to date has included physical therapy, home exercise program, knee injections, shoulder injection, lumbar tendon sheath injection, and medications including Celebrex 200mg taken twice daily as needed (since March 2013), which provides some pain relief and functional improvements. Utilization review from December 9, 2013 denied the request for outpatient lumbar transforaminal epidural steroid injection (TESI) at L2-3 and L4-5 bilaterally; and pharmacy purchase of Celebrex 200mg #60. The rationale for determination was not included in the records for review. Medical records from 2012 through 2014 were reviewed, which showed that the patient complained of constant and aching right shoulder, right wrist, right hand, bilateral thumb, right hip, and right knee pain, rated 3/10 with medications, and 9/10 at worst. The patient also reported difficulties with activities of daily living and walking/running. Exacerbating factors included lying down on the back, lying down on the side, squatting, standing, and walking. Alleviating factors included cold, heat, medications, and warm baths. On physical examination, posture was abnormal with guarding of the low back. Cervical range of motion showed limited right and left rotation with moderate tenderness along the right cervical paraspinal muscles. Lumbar spine examination showed no scoliosis, asymmetry, or abnormal curvature but limitation of flexion and extension was noted. There was also mild tight band, mild spasm, mild hypertonicity, and moderate tenderness along the bilateral lumbar area. Straight leg raise maneuver was moderately positive at bilateral L4 and L5 for radicular symptomatology. Facet distraction/loading maneuvers were positive moderately at bilateral L3-L4 and L4-L5 for axial lumbar pain. Tenderness was also noted along the sacral spine and on the SI joints bilaterally. Moderate levator scapula tenderness was also noted. Right shoulder examination showed positive Neer's, Hawkin's, O'Brien's, and Empty can tests. Speeds test was negative. On palpation, there was mild tenderness along the acromioclavicular joint. Right wrist examination

showed restricted range of motion. Right hand examination showed tenderness over the 1st carpal-metacarpal joint but Sauck and Finkelstein tests were negative. Right hip examination showed restricted range of motion with tenderness over the trochanter and a positive FABER test. Right knee examination showed anterior scars and limited range of motion with tenderness along the medial joint line and quadriceps tendon. Anterior drawer, Lachman, pivot shift, posterior drawer, reverse pivot shift, and McMurray's tests were negative. Patellar grind test was positive. There was a 1+ effusion noted in the right knee joint. Sensation was decreased along the bilateral L2, L3, L4, and L5 distribution. Motor examination showed mild weakness on ankle dorsiflexion, ankle plantarflexion, and extensor hallucis longus bilaterally.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **OUTPATIENT LUMBAR TRANSFORAMINAL EPIDURAL STEROID INJECTION (TESI) AT L2-3 AND L4-5 BILATERALLY: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection Section.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection Section Page(s): 46. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES PHYSICAL MEDICINE, , 46

**Decision rationale:** According to page 46 of the Chronic Pain Medical Treatment Guidelines, epidural injections are not supported in the absence of objective radiculopathy. In addition, criteria for the use of epidural steroid injections include an imaging study documenting correlating concordant nerve root pathology; and conservative treatment. In this case, although physical examination findings of radiculopathy were reported, there were no imaging studies included in the records for review that supported findings of radiculopathy. Furthermore, there was no discussion regarding failure of conservative management. Therefore, the request for outpatient lumbar transforaminal epidural steroid injection (tesi) at l2-3 and l4-5 bilaterally is not medically necessary.

#### **CELEBREX 200MG #60: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAID Section Page(s): 22.

**Decision rationale:** According to page 22 of the Chronic Pain Medical Treatment Guidelines, NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain, and that Celebrex may be considered if the patient has a risk of GI complications, but not for the majority of patients. In addition, guidelines state that anti-inflammatories are the traditional first line of treatment to reduce pain but long-term use may not be warranted. In this

case, the patient has been taking Celebrex since March 2013 (14 months to date) and although some pain relief and functional improvements were reported with this medication, guidelines state that long-term use of NSAIDs are not recommended. Furthermore, the medical reports do not indicate that the patient is at risk of GI complications, which may warrant the use of Celebrex over other NSAIDs. Therefore, the request for Celebrex 200MG #60 is not medically necessary.