

<b>Case Number:</b>	CM14-0157936		
<b>Date Assigned:</b>	10/01/2014	<b>Date of Injury:</b>	10/25/2013
<b>Decision Date:</b>	12/17/2014	<b>UR Denial Date:</b>	09/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/26/2014

### 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 Family 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:

This is a 43-year-old male patient who reported an industrial injury to the back on 10/25/2013, fourteen (14) months ago, attributed to the performance of his usual and customary job tasks. The mechanism of injury was reported as moving a wheelchair when the occupant moved it back, rolling over the patient's foot causing him to pull the foot from underneath the wheelchair resulting in twisting his back and right knee. The patient has received treatment with physical therapy; aquatic therapy; ankle brace; boot cast; medications; and activity modifications. The patient has used Aleve with some relief, whereas, all the other medicines caused GI upset. X-rays of the lumbar spine dated 11/25/2013, were assessed as normal. The MRI of the lumbar spine dated 12/19/2013, documented early disc desiccation at L1-L2; mild impingement of the right fifth nerve root in the neural foramina; lateral recess stenosis bilaterally at L4-L5. X-rays of the right foot documented some enthesopathy of the distal right Achilles tendon. There was no documentation of the 8/17/2014, EMG/NCS results. The QME evaluation dated 5/16/2014, recommended additional treatment as a PT/exercise program. The objective findings on examination included antalgic gait; unable to heel or toe walk; tenderness to palpation of the lumbar spine midline and right paraspinal region; reduced range of motion to the lumbar spine; sensation was diminished at the right L3, L4, L5, and S1 dermatomes; muscle strength 4+/5; trochanteric bursitis on the right side; range of motion of the knee with pain. The patient was diagnosed with a lumbosacral neuritis, lumbar radiculopathy, lumbar stenosis, right hip trochanteric bursitis, right knee pain, and right foot pain. The patient was authorized a bilateral lower extremity EMG/NCS. The patient was also ordered a transforaminal ESI to right L5-S1 and ketoprofen 20% topical cream.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TFESI Right L5-S1, Diagnostic and Therapeutic:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46.  
Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300;179-80, Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46.  
Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter Lumbar Spine, ESI.

**Decision rationale:** The criteria required by the CA MTUS for the provision of a lumbar ESI were not documented by the requesting provider. The patient is noted to be 14 months status post date of injury with lumbar spine DDD and a subjective radiculopathy. The patient does meet the CA MTUS criteria for a lumbar ESI under fluoroscopic guidance. The use of lumbar spine ESIs is recommended for the treatment of acute or subacute radicular pain in order to avoid surgical intervention. The patient is noted to have objective findings on examination consistent with a nerve impingement radiculopathy; however, there is no objective evidence in the form of imaging studies or Electrodiagnostic studies documenting a nerve impingement radiculopathy to support the medical necessity of the requested ESI. The patient has just been authorized Electrodiagnostic studies to confirm a lumbar radiculopathy. The reported radiculopathy was not corroborated by imaging studies or Electrodiagnostic studies. There is no impending surgical intervention. The patient is being treated for chronic low back pain attributed to lumbar spine DDD. The patient is documented to of had a rehabilitation effort along with physical therapy; however, the last office visit documented reported neurological deficits along a dermatomal distribution to the bilateral lower extremities. The stated diagnoses and clinical findings do not meet the criteria recommended by evidence-based guidelines for the use of a lumbar ESI by pain management. The CA MTUS requires that "Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or Electrodiagnostic testing." The ACOEM Guidelines updated Back Chapter revised 8/08/08 does not recommend the use of lumbar ESIs for chronic lower back pain. The Official Disability Guidelines recommend that ESIs are utilized only in defined radiculopathies and a maximum of two (2) lumbar diagnostic ESIs and a limited number of therapeutic lumbar ESIs are recommended in order for the patient to take advantage of the window of relief to establish an appropriate self-directed home exercise program for conditioning and strengthening. The criteria for a second diagnostic ESI is that the claimant obtain at least 50% relief from the prior appropriately placed ESI. The therapeutic lumbar ESIs are only recommended, "If the patient obtains 50-70% pain relief for at least 6-8 weeks." Additional blocks may be required; however, the consensus recommendation is for no more than four (4) blocks per region per year. The indications for repeat blocks include "acute exacerbations of pain or new onset of symptoms." Lumbar ESIs should be performed at no more than two (2) levels at a session. Although epidural injection of steroids may afford short-term improvement in the pain and sensory deficits in patients with radiculopathy due to herniated nucleus pulposus, this treatment, per the guidelines, seems to offer no significant long-term functional benefit, and the number of injections should be limited to two (2), and only as an

option for short-term relief of radicular pain after failure of conservative treatment and as a means of avoiding surgery and facilitating return to activity. The patient is being treated for a subjective radiculitis with reported chronic low back without MRI or EMG/NCV evidence of a nerve impingement radiculopathy. There is no demonstrated medical necessity for a lumbar spine ESI for the reported chronic pain issues. The request for a Lumbar Spine TFLESI at right L5-S1 is not medically necessary.

**Ketoprofen 20% cream:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Page(s): 111-112.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, NSAIDs Page(s): 111-113;22,67-68,71. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) chapter 6, pages 114-15; Official Disability Guidelines (ODG), Topical Analgesics and NSAIDs

**Decision rationale:** The patient has been prescribed topical ketoprofen 20% cream for chronic pain. The patient has received topical NSAID cream for a prolonged period of time exceeding the time period recommended by evidence-based guidelines. There is no demonstrated medical necessity for both an oral NSAID and a topical NSAID. There is no provided subjective or objective evidence that the patient has failed or not responded to other conventional and recommended forms of treatment for relief of the effects of the industrial injury. Only if the subjective/objective findings are consistent with the recommendations of the CA MTUS, then topical use of topical preparations is only recommended for short-term use for specific orthopedic diagnoses. There is no documented functional improvement by the provider attributed to the topical NSAID. The use of topical NSAIDS is documented to have efficacy for only 2-4 weeks subsequent to injury and thereafter is not demonstrated to be as effective as oral NSAIDs. There is less ability to control serum levels and dosing with the topicals. The patient is not demonstrated to have any GI issue at all with NSAIDS. The patient was prescribed an oral opioids and topical NSAID concurrently. The use of the topical creams/gels does not provide the appropriate therapeutic serum levels of medications due to the inaccurate dosing performed by rubbing variable amounts of creams on areas that are not precise. The volume applied and the times per day that the creams are applied are variable and do not provide consistent serum levels consistent with effective treatment. There is no medical necessity for the addition of creams to the oral medications in the same drug classes. There is no demonstrated evidence that the topicals are more effective than generic oral medications. The prolonged use of topical ketoprofen 20% cream not supported by the applicable evidence-based guidelines. The continued use of topical NSAIDs for the current clinical conditions is not otherwise warranted or demonstrated to be medically necessary. The request for topical ketoprofen 20% cream is not medically necessary.