

Case Number:	CM14-0166569		
Date Assigned:	10/29/2014	Date of Injury:	02/18/2014
Decision Date:	12/05/2014	UR Denial Date:	10/03/2014
Priority:	Standard	Application Received:	10/09/2014

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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Georgia. 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:

The patient is a 37 years old male presenting with a work injury on 02/18/2014. On 06/17/2014, the patient complained of sharp pain in the lower back radiating down his left leg. The physical exam showed midline tenderness of the left lower spine, paraspinous muscle tenderness of the left side. MRI of the lumbar spine showed L3-4 annular disc bulging that is eccentric to the left L4-5 4-5 mm central disc bulging. The patient was diagnosed with low back pain radiating to the left leg and lumbar radicular pain. The patient's medications included Flector Patch, Celebrex, Tramadol and Lyrica.

IMR ISSUES, DECISIONS AND RATIONALES

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

(L) L4-L5, L5-S1 Transforaminal Epidural Steroid Injection under Fluroscopic guidance, up to 3 per year: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESI's).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection Page(s): 47.

Decision rationale: (L) L4-L5, L5-S1 Transforaminal Epidural Steroid Injection under Fluroscopic guidance, up to 3 per year is not medically necessary. The California MTUS page 47

states "the purpose of epidural steroid injections 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 is no significant long-term functional benefit. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Initially unresponsive to conservative treatment, injections should be performed using fluoroscopy, if the ESI is for diagnostic purposes a maximum of 2 injections should be performed. No more than 2 nerve root levels should be injected using transforaminal blocks. No more than 1 interlaminar level should be injected at one session. 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 6-8 weeks, with the general recommendation of no more than 4 blocks per region per year. Current research does not support a series of 3 injections in either the diagnostic or therapeutic phase. We recommend no more than 2 epidural steroid injections." The physical exam and MRI results does not corroborate lumbar radiculitis; Additionally, MTUS guidelines does not support more than 2 epidural steroid injections; therefore, the requested services is not medically necessary.

Facet Injections (unspecified): Upheld

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

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 Complaints, Treatment Considerations

Decision rationale: Facet Injections (Unspecified) is not medically necessary. The Occupation medicine practice guidelines criteria for use of diagnostic facet blocks require: that the clinical presentation be consistent with facet pain; Treatment is also limited to patients with cervical pain that is nonradicular and had no more than 2 levels bilaterally; documentation of failed conservative therapy including home exercise physical therapy and NSAID is required at least 4-6 weeks prior to the diagnostic facet block; no more than 2 facet joint levels are injected at one session; recommended by them of no more than 0.5 cc of injectate was given to each joint; no pain medication from home should be taken for at least 4 hours prior to the diagnostic block and for 4-6 hours afterward; opioid should not be given as a sedative during the procedure; the use of IV sedation (including other agents such as modafinil) may interfere with the result of the diagnostic block, and should only be given in cases of extreme anxiety; the patient should document pain relief with the management such as VAS scale, emphasizing the importance of recording the maximum pain relief and maximum duration of pain. The patient should also keep medication use and activity level to support subjective reports of better pain control; diagnostic blocks should not be performed in patients in whom a surgical procedures anticipated; diagnostic facet block should not be performed in patients who have had a previous fusion procedure at the plan injection level. The physical exam does not clearly indicate facet pain; therefore the requested procedure is not medically necessary.

TENS (transcutaneous electrical nerve stimulation) Unit: 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 TENS Page(s): 114.

Decision rationale: TENS (transcutaneous electrical nerve stimulation) Unit is not medically necessary. Page 114 of MTUS states that a one month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to an evidence based functional restoration program. As it relates to this case TENS unit was recommended as solo therapy and not combined with an extensive functional restoration program. Per MTUS TENS unit is not medically necessary as solo therapy.

Urine Tox Screen: Overturned

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 Substance Abuse Page(s): 97.

Decision rationale: Urine Tox Screen is medically necessary. Per Ca MTUS guideline on urine drug screen to assess for the use or the presence of illegal drugs as an option in patients on chronic opioids, and recommend screening for the risk of addiction prior to initiating opioid therapy. (1) However, these guidelines did not address the type of UDS to perform, or the frequency of testing. The ODG guidelines also recommends UDS testing using point of care immunoassay testing prior to initiating chronic opioid therapy, and if this test is appropriate, confirmatory laboratory testing is not required. Further urine drug testing frequency should be based on documented evidence of risk stratification including use of the testing instrument with patients' at low risk of addiction, aberrant behavior. There is no reason to perform confirmatory testing unless tests is an appropriate orders on expected results, and if required, a confirmatory testing should be for the question drugs only. If urine drug test is negative for the prescribed scheduled drug, confirmatory testing is strongly recommended for the question drug. (2) The claimant is on Tramadol. Tramadol is a medication that can be abused. If his last urine drug screen was greater than four months prior then another test is recommended to assess his use of the medication; therefore the requested services is medically necessary.

Radiofrequency Ablation Under Fluoroscopic Guidance: Upheld

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

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 Complaints, Treatment Consideration

Decision rationale: Radiofrequency Ablation Under Fluoroscopic Guidance is not medically necessary. MTUS references the Occupation medicine practice guidelines on page 300 which states that "Lumbar facet neurotomies reportedly produce mixed results. Facet neurotomies should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks." Additionally, The Occupation medicine practice guidelines criteria for use of diagnostic facet blocks require that the clinical presentation be consistent with facet pain. Treatment is also limited to patients with low back pain that is nonradicular and had no more than 2 levels bilaterally documentation of failed conservative therapy including home exercise physical therapy and NSAID is required prior to the diagnostic facet block. The physical exam did not clearly indicate facet pain an there was no documentation of positive facet injections quantifying greater than 50% reduction in pain. The requested service is, therefore not medically necessary.