

Case Number:	CM14-0078456		
Date Assigned:	08/15/2014	Date of Injury:	01/12/2004
Decision Date:	09/22/2014	UR Denial Date:	05/27/2014
Priority:	Standard	Application Received:	05/28/2014

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 Medicine and is licensed to practice in Texas. 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 injured worker is a 53 year old female injured on 01/12/04 while lifting a desk followed by four separate surgical interventions. The injured worker continued to complain of severe low back pain radiating to the posterior aspect of the left lower extremity into the bottom of the foot. The injured worker also complained of upper back pain in addition to neck pain and headaches. The injured worker underwent transforaminal epidural steroid injection on 08/02/13, physical therapy, chiropractic therapy, acupuncture, and medication management. Clinical note dated 11/08/13 indicated the injured worker presented complaining of low back and left lower extremity pain rated 10/10. The injured worker reported increasing pain with right lower extremity pain. Prior magnetic resonance image of the lumbar spine on 03/15/12 revealed L3-4 minimal broad based disc bulge with left lateral disc protrusion and mild caudal left neural foraminal narrowing, L4-5 post-surgical changes with facet arthropathy mild left neural foraminal narrowing with no central stenosis, and L5-S1 post-operative changes no evidence of central neural foraminal stenosis. Physical examination revealed antalgic gait with cane moderate midline tenderness to cervical spine/thoracic spine/lumbar spine, decreased range of motion of the cervical spine/lumbar spine/thoracic spine, 4/5 muscle strength to the right lower extremity, 3/5 to the left, reduced sensation to light touch along anterior and lateral left thigh and anterior left leg, positive straight leg raise on the left at 45 degrees and negative on the right, and negative Faber test bilaterally. Diagnoses included degenerative disc disease in the lumbar spine, upper back pain, neck pain, and chronic headaches. Medications included tramadol, Lyrica, Zanaflex, Voltaren gel 1%, Lidoderm patches 5%, Nexium, and Phenergan. Initial request was non-certified on 05/27/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar ESI (Epidural Steroid Injection) bilateral L4-L5: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46.

Decision rationale: As noted on page 46 of the Chronic Pain Medical Treatment Guidelines, epidural steroid injections are recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). 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. There was no documentation regarding the quantitative measurement of pain relief achieved with prior epidural steroid injections. As such, the request for Lumbar ESI (Epidural Steroid Injection) Bilateral L4-L5 cannot be recommended as medically necessary.

Lumbar ESI (Epidural Steroid Injection) Left (L5-S1): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46.

Decision rationale: As noted on page 46 of the Chronic Pain Medical Treatment Guidelines, epidural steroid injections are recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). 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. There was no documentation regarding the quantitative measurement of pain relief achieved with prior epidural steroid injections. As such, the request for Lumbar ESI (Epidural Steroid Injection) Left (L5-S1) cannot be recommended as medically necessary.

Flexeril 10mg, #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasmodics; Muscle Relaxants (For Pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 41.

Decision rationale: As noted on page 41 of the Chronic Pain Medical Treatment Guidelines, cyclobenzaprine is recommended as a second-line option for short-term (less than two weeks)

treatment of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. Studies have shown that the efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. Based on the clinical documentation, the injured worker has exceeded the 2-4 week window for acute management also indicating a lack of efficacy if being utilized for chronic flare-ups. As such, the medical necessity of Flexeril 10mg, #90 cannot be established at this time.

Voltaren Gel 1%, #5: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Voltaren Gel (diclofenac) Page(s): 112.

Decision rationale: Voltaren Gel (diclofenac) is not recommended as a first-line treatment. Diclofenac is recommended for osteoarthritis after failure of an oral non-steroidal anti-inflammatory drug (NSAID), contraindications to oral NSAIDs, or for patients who cannot swallow solid oral dosage forms, and after considering the increased risk profile with diclofenac, including topical formulations. According to Food and Drug Administration MedWatch, post-marketing surveillance of diclofenac has reported cases of severe hepatic reactions, including liver necrosis, jaundice, fulminant hepatitis with and without jaundice, and liver failure. With the lack of data to support superiority of diclofenac over other NSAIDs and the possible increased hepatic and cardiovascular risk associated with its use, alternative analgesics and/or non-pharmacological therapy should be considered. As such the request for Voltaren Gel 1%, #5 cannot be recommended as medically necessary at this time.

Lidoderm Patches 5%, #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidocaine Patch, Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (lidocaine patch) Page(s): 56.

Decision rationale: As noted on page 56 of the Chronic Pain Medical Treatment Guidelines, the safety and efficacy of compounded medications has not been established through rigorous clinical trials. Lidoderm is recommended for a trial if there is evidence of localized pain that is consistent with a neuropathic etiology. There should be evidence of a trial of first-line neuropathy medications (tri-cyclic or Serotonin-norepinephrine reuptake inhibitors anti-depressants or an anti-epileptic drug such as gabapentin or Lyrica). Lidoderm is not generally recommended for treatment of osteoarthritis or treatment of myofascial pain/trigger points. Therefore Lidoderm Patches 5%, #90 cannot be recommended as medically necessary as it does not meet established and accepted medical guidelines.

Nexium 20mg, #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter: Proton Pump Inhibitors (PPIs).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Proton Pump Inhibitors.

Decision rationale: As noted in the Official Disability Guidelines - Online version, Pain Chapter, proton pump inhibitors are indicated for patients at intermediate and high risk for gastrointestinal events with concurrent use of non-steroidal anti-inflammatory drug (NSAID) use. Risk factors for gastrointestinal events include age > 65 years; history of peptic ulcer, gastrointestinal bleeding or perforation; concurrent use of aspirin (ASA), corticosteroids, and/or an anticoagulant; or high dose/multiple NSAID (e.g., NSAID + low-dose ASA). There is no indication that the injured worker is at risk for gastrointestinal events requiring the use of proton pump inhibitors. Furthermore, long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture. As such, the request for Nexium 20mg, #30 cannot be established as medically necessary.

Physical Therapy/Pool Therapy (12 Sessions): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic Therapy/Physical Medicine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98.

Decision rationale: As noted on page 98 of the Chronic Pain Medical Treatment Guidelines, current guidelines recommend 1-2 visits post-injection and allow for fading of treatment frequency (from up to 3 or more visits per week to 1 or less), plus active self-directed home physical therapy. However, due to non-recommendation of the requested epidural steroid injections, the request for Physical Therapy/Pool Therapy (12 Sessions) cannot be recommended as medically necessary.