MAXIMUS Federal Services

Case Number:	CM14-0188388		
Date Assigned:	11/19/2014	Date of Injury:	04/22/2006
Decision Date:	01/07/2015	UR Denial Date:	10/27/2014
Priority:	Standard	Application Received:	11/12/2014

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 Preventive Medicine, has a subspecialty in Occupational Medicine and is licensed to practice in Iowa. 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 63 year old injured worker with date of injury of 04/22/2006. Medical records indicate the injured worker is undergoing treatment for post lumbar interbody fusion at L3-4, L4-5 and L5-S1. Subjective complaints include lower back pain, worse during cold weather; increased pain with sitting, standing, walking and sleeping; pain radiates down the front of bilateral legs to the feet; numbness in feet when sitting for long periods. Objective findings include slow and guarded gait, no difficulty with toe or heel ambulation, lumbar flexion with fingertips to the thighs, extension to neutral, bilateral lateral flexion 10 degrees, normal motor strength, numbness in the plantar feet bilaterally; 0/2 reflexes symmetrically in the lower extremities; negative SLR; midline lumbosacral tenderness. Treatment has consisted of EMG/NCS, Vicodin, Soma, TENS unit. MRI on 03/02/2012 shows: Status post disc prosthesis, laminectomy and posterior fixation hardware, L3-4, L4-5, L5-S1. No significant canal stenosis at operative levels. Some stenosis at junction of lateral recesses and foramina, likely related to residual bulging disc/osteophyte and/or post-fusion residuals. No recurrent disc herniation appreciated. L2-3, moderate to severe canal stenosis, moderate to severe right and moderate left foraminal stenosis. L1-2 bulging disc//osteophyte with mild to moderate canal and mild to moderate bilateral foraminal stenosis. SI joint WNL, possible mild arachnoiditis. Fluid collection posteriorly at L4-5, no evidence of enhancement or infection. CT of lumbar spine dated 04/30/2012: extensive postsurgical changes showing interpedicular screws and disc spacers at L3-4, L4-5 and L5-S1. There are laminectomies noted. There is some bilateral foraminal stenosis at these levels secondary to osteophytes. Mild diffuse bulge at L2-3 associated with bilateral moderate foraminal stenosis. There are not lytic or blastic lesions noted. The utilization review determination was rendered on 10/27/2014 recommending non-certification of Lumbar ESI bilateral L5-S1 and S1 transforaminal ESI under fluoroscopic guidance and 1 Prescription for Ambien 10mg #30.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar ESI Bilateral L5-S1 and S1 Transforaminal ESI under Fluoroscopic Guidance: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ESIs. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315,Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs) Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Facet joint Diagnostic Blocks (Injections), Epidural Steroid Injections (ESIs), Therapeutic and MD Guidelines, Facet Joint Injections/Therapeutic Facet Joint Injections

Decision rationale: ACOEM Guidelines state "Invasive techniques (e.g., local injections and facet-joint injections of cortisone and lidocaine) are of questionable merit. Although epidural steroid injections may afford short-term improvement in leg pain and sensory deficits in patients with nerve root compression due to a herniated nucleus pulposus, this treatment offers no significant long term functional benefit, nor does it reduce the need for surgery. Despite the fact that proof is still lacking, many pain physicians believe that diagnostic and/or therapeutic injections may have benefit in patients presenting in the transitional phase between acute and chronic pain." ODG and MD Guidelines agree that: "One diagnostic facet joint injection may be recommended for patients with chronic low back pain that is significantly exacerbated by extension and rotation or associated with lumbar rigidity and not alleviated with other conservative treatments (e.g., NSAIDs, aerobic exercise, other exercise, manipulation) in order to determine whether specific interventions targeting the facet joint are recommended. If after the initial block/blocks are given (see "Diagnostic Phase" above) and found to produce pain relief of at least 50-70% pain relief for at least 6-8 weeks, additional blocks may be supported." Medical documentation provided indicates that this injured worker has had previous injections that did not provide functional improvement and the injured worker was apprehensive about repeat injections. Guidelines state "Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response." Furthermore, decreased success rates have been found in patients who have had previous spine surgeries. As such, the request for Lumbar ESI Bilateral L5-S1 and S1 Transforaminal ESI under Fluoroscopic Guidance is not medically necessary.

Prescription for Ambien 10mg #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

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

Decision rationale: The CA MTUS is silent regarding this topic. ODG states that Zolpidem is a prescription "short acting non-benzodiazepine hypnotic," which is approved for "short-term treatment of insomnia." There has been no discussion of the patient's sleep hygiene or the need for variance from the guidelines, such as "a) Wake at the same time everyday; (b) Maintain a consistent bedtime; (c) Exercise regularly (not within 2 to 4 hours of bedtime); (d) Perform relaxing activities before bedtime; (e) Keep your bedroom quiet and cool; (f) Do not watch the clock; (g) Avoid caffeine and nicotine for at least six hours before bed; (h) Only drink in moderation; & (i) Avoid napping." Medical documents also do not include results of these first line treatments, if they were used in treatment of the patient's insomnia. ODG additionally states, "The specific component of insomnia should be addressed: (a) Sleep onset; (b) Sleep maintenance; (c) Sleep quality; & (d) Next-day functioning." Long term use of hypnotics in not recommended due to being habit forming, functional and memory impairment and the potential for increasing pain and depression over the long term. As such, the request for Prescription for Ambien 10mg #30 is not medically necessary.