

Case Number:	CM14-0202078		
Date Assigned:	12/12/2014	Date of Injury:	09/22/2010
Decision Date:	02/03/2015	UR Denial Date:	12/02/2014
Priority:	Standard	Application Received:	12/02/2014

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 and is licensed to practice in Indiana. 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:

According to the records made available for review, this is a 55-year-old male with a date of injury on 09/22/2010. Medical records provided did not indicate the injured worker's mechanism of injury. Documentation from 11/25/2014 indicated the diagnoses of degeneration of lumbar or lumbosacral intervertebral disc, generalized osteoarthritis, unspecified thoracic or lumbosacral neuritis or radiculitis, sacroiliitis not elsewhere specified, gastroesophageal reflux disease, degeneration of lumbar intervertebral disc, lumbar radiculopathy, and knee pain. Subjective findings from 11/25/2014 were remarkable for an increase in lower right back pain that radiated down the hip and into the foot. The injured worker rates the pain a nine out of ten without medication and an eight out of ten with medication. Associated symptoms included a disturbance in sleep pattern and heartburn. The pain was also noted to interfere moderately to severe with relationships, work, concentration, mood, sleep, and overall functioning. Physical examination performed on this date was revealing for a slight limp to the right side and lumbar tenderness upon palpation including to the sacroiliac joint with flexion at fifty percent. Sensory examination indicated hypoesthesia and dysesthesia to the bilateral feet and right hip. The treating physician noted that examination was unable to be performed secondary to extreme pain. The records from 11/25/2014 referenced the results of magnetic resonance imaging performed on 11/24/2010 that revealed multi-level degenerative disc disease and facet arthropathy without central canal stenosis of the lumbar spine. On 08/22/2014 x-rays of the right hip was performed that was remarkable for mild right hip osteoarthritis. Medical records provided refer to prior treatments and therapies that included use of ice, heat, rest, gentle stretching, exercises, lumbar steroid epidural injection on 07/08/2014, aqua therapy, and a medication history of Naproxen, Prilosec, Pepcid, Colace, and Senna. Documentation from 11/25/2014 noted that the injured worker reported a sixty to seventy percent relief from the epidural steroid injection performed on

07/08/2014 that lasted five months. The medical records provided did not indicate specific details with regards to functional improvement, improvement in work function, or in activities of daily living. The medical records also lacked documentation of the injured worker's work status or disability status. On 12/02/2014, Utilization Review non-certified the prescription for repeat bilateral lumbar five to sacral one epidural steroid injection and non-certified the prescription for Prilosec 20mg for a quantity of thirty as prescribed on 11/25/2014. The repeat bilateral lumbar five to sacral one epidural steroid injection was noncertified based on CA MTUS Chronic Pain Guidelines, epidural steroid injections, with the Utilization Review noting that there was no documentation of a previous epidural that resulted in functional improvement with a reduction in pain medication. The prescription for Prilosec was noncertified based on CA MTUS Chronic Pain Guidelines, non-steroidal anti-inflammatory drugs, gastrointestinal symptoms & cardiovascular risk, with the Utilization Review noting that there was no documentation indicating the use of Prilosec to be effective in treating reflux along with no documentation as to why two gastrointestinal protectant medications are being used.

IMR ISSUES, DECISIONS AND RATIONALES

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

Repeat bilateral L5-S1 epidural steroid injection (ESI): Upheld

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

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. Other Medical Treatment Guideline or Medical Evidence: 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." The 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." Treating physician does not document at least 50% pain relief but does not comment on any functional improvement. Per the ODG, "Indications for repeat blocks include acute exacerbation of pain, or

new onset of radicular symptoms. Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response." The treating physician does not document any acute exacerbation of pain, new radicular symptoms, continued objective pain relief, or functional response. As such, the request for Repeat bilateral L5-S1 epidural steroid injection (ESI) is not medically necessary.

Prilosec 20 mg, thirty count: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms & Cardiovascular Risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), NSAIDs, GI symptoms & cardiovascular risk.

Decision rationale: The MTUS states "Determine if the patient is at risk for gastrointestinal events: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or(4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA)." And "Patients at intermediate risk for gastrointestinal events and no cardiovascular disease:(1) A non-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg omeprazole daily) or misoprostol (200 g four times daily) or (2) a Cox-2 selective agent. Long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture (adjusted odds ratio 1.44)." The medical documents provided do not establish the patient has having documented GI bleeding/perforation/peptic ulcer or other GI risk factors as outlined in MTUS. Additionally, there is no evidence provided to indicate the patient suffers from dyspepsia because of the present medication regimen. As such, the request for Omeprazole 20mg #30 is not medically necessary.