

Case Number:	CM14-0205714		
Date Assigned:	12/17/2014	Date of Injury:	05/23/2012
Decision Date:	02/13/2015	UR Denial Date:	11/22/2014
Priority:	Standard	Application Received:	12/09/2014

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 Acupuncture & Pain 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:

62y/o male injured worker with date of injury 5/23/12 with related neck, low back, and right lower extremity pain. Per progress report dated 11/18/14, the injured worker was status post right knee lateral meniscectomy, chondroplasty, and debridement. He stated his neck pain had worsened. He also stated he was having an increase in numbness and tingling to his bilateral extremities. He had tried epidural injections in the past with benefit. He stated his pain was reduced by about 1/2 for 2 months before it begins to wear off. MRI of the cervical spine revealed 2-3mm disc protrusion at C5-C6 with facet arthropathy and spinal canal stenosis. Treatment to date has included physical therapy, epidural steroid injections, and medication management. The date of UR decision was 11/21/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Cervical Epidural injection at C5-6, each additional level(x3): Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46.

Decision rationale: Per the MTUS CPMTG epidural steroid injections are used 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 offers no significant long-term benefit. The criteria for the use of epidural steroid injections are as follows: 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing.2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants).3) Injections should be performed using fluoroscopy (live x-ray) for guidance.4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections.5) No more than two nerve root levels should be injected using transforaminal blocks.6) No more than one interlaminar level should be injected at one session.7) 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 six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007)8) Current researches do not support a "series-of-three" injection in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections. The documentation submitted for review indicates that the injured worker has had epidural injections in the past with benefit. He stated his pain was reduced by about 50% for two months before it began to wear off. He was able to sleep better and was able to do more in terms of activities. I respectfully disagree with the UR physician, the documentation supports repeat injection. The request is medically necessary.

1 Cervical epidurogram: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46.

Decision rationale: Per the MTUS guidelines with regard to epidural steroid injections: 3) Injections should be performed using fluoroscopy (live x-ray) for guidance. The request is medically necessary.

1 Insertion of the cervical catheter: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46.

Decision rationale: Epidural techniques do involve injection of drugs through a catheter placed into the epidural space. As the CESI at C5-C6 is warranted, the request is medically necessary.

IV Sedation: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Epidural Steroid Injections

Decision rationale: Per the ODG guidelines, Sedation: There is no evidence-based literature to make a firm recommendation as to sedation during an ESI. The use of sedation introduces some potential diagnostic and safety issues, making unnecessary use less than ideal. A major concern is that sedation may result in the inability of the patient to experience the expected pain and paresthesias associated with spinal cord irritation. This is of particular concern in the cervical region. (Hodges 1999) Routine use is not recommended except for patients with anxiety. The least amount of sedation for the shortest duration of effect is recommended. The general agent recommended is a benzodiazepine. The request is not medically necessary.

Tramadol HCL ER 100mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78, 93.

Decision rationale: Per MTUS Chronic Pain Medical Treatment Guidelines page78 regarding on-going management of opioids "Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: Pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug related behaviors. These domains have been summarized as the '4 A (s)' (Analgesia, activities of daily living, adverse side effects, and any aberrant drug-taking behaviors).The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs."Review of the available medical records reveals no sufficient documentation to support the medical necessity of Tramadol or sufficient documentation addressing the'4 A's' domains as it is a recommended practice for the on-going management of opioids. Specifically, the notes do not appropriately review and document pain relief or appropriate medication use. The MTUS considers this list of criteria for initiation and continuation of opioids in the context of efficacy required to substantiate medical necessity, and they do not appear to have been addressed by the treating physician in the documentation available for review. It was noted that the medication provided relief particularly in regard to improving the injured worker's tolerance for standing and walking, however no quantified measure of pain relief was provided. Furthermore, efforts to rule out aberrant behavior (e.g. CURES report, urine drug screen (UDS), opiate agreement) are necessary to assure safe usage and establish medical necessity. There is no documentation comprehensively addressing

this concern in the records available for my review. As MTUS recommends discontinuing opioids if there is no overall improvement in function, medical necessity cannot be affirmed.

Pantoprazole 20mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms, & Cardiovascular Risk Page(s): 68. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Proton Pump Inhibitors.

Decision rationale: In the treatment of dyspepsia secondary to NSAID therapy, the MTUS recommends stopping the NSAID, switching to a different NSAID, or considering the use of an H2-receptor antagonist or a PPI. The MTUS Chronic Pain Medical Treatment Guidelines recommend the use of proton pump inhibitors in conjunction with NSAIDs in situations in which the patient is at risk for gastrointestinal events including: (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). CPMTG guidelines further specify: "Recommendations: Patients with no risk factor and no cardiovascular disease: Non-selective NSAIDs OK (e.g., Ibuprofen, Naproxen, etc.) 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 (200g 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). Patients at high risk for gastrointestinal events with no cardiovascular disease: A Cox-2 selective agent plus a PPI if absolutely necessary. Patients at high risk of gastrointestinal events with cardiovascular disease: If GI risk is high the suggestion is for a low-dose Cox-2 plus low dose Aspirin (for cardio protection) and a PPI. If cardiovascular risk is greater than GI risk the suggestion is Naproxyn plus low-dose Aspirin plus a PPI. (Laine, 2006) (Scholmerich, 2006) (Nielsen, 2006) (Chan, 2004) (Gold, 2007) (Laine, 2007)"Per ODG TWC, "many prescribers believe that this class of drugs is innocuous, but much information is available to demonstrate otherwise. A trial of Omeprazole or Lansoprazole is recommended before Nexium therapy. The other PPIs, Protonix, Dexilant, and Aciphex, should also be second-line."As there is no documentation of peptic ulcer, GI bleeding or perforation, or cardiovascular disease in the records available for my review, the injured worker's risk for gastrointestinal events is low, as such, medical necessity cannot be affirmed. Furthermore, as noted per the guidelines, Protonix is a second-line medication. The medical records indicate that the injured worker used Prilosec in the past, and that it was not failed. It should be considered prior to prescribing a second line PPI such as Protonix. The request is not medically necessary.

1 fluoroscopic guidance: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46.

Decision rationale: Per the MTUS guidelines with regard to epidural steroid injections: 3) Injections should be performed using fluoroscopy (live x-ray) for guidance. The request is medically necessary.