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| Case Number: | CM15-0103231 | | |
| Date Assigned: | 06/05/2015 | Date of Injury: | 07/21/2011 |
| Decision Date: | 07/14/2015 | UR Denial Date: | 05/08/2015 |
| Priority: | Standard | Application Received: | 05/29/2015 |

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Emergency Medicine

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 46 year old, male who sustained a work related injury on 7/21/11. He was carrying 60 pipes while walking and slipped back and fell on wet ground. He felt pain in his low back. The diagnoses have included lumbar discogenic disease with radicular findings and cervical discogenic disease. Treatments have included medications, physical therapy, home exercises and IFC E-Stim treatments. In the PR-2 dated 4/20/15, the injured worker complains of constant, severe cervical and lumbar pain. He states the pain is no better. He has spasms to palpation of trapezius muscles. He has decreased range of motion in neck. He states all pain in his neck goes into both shoulders. He has decreased range of motion in lumbar spine. He states all pain goes down into legs. He has positive straight leg raises with right leg at 10 degrees and left leg at 20 degrees. He is angry and wants more to be done. The treatment plan includes prescription refills of medications and a request for a lumbar epidural steroid injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Epidural steroid injection (ESI) at L4-5 at DMC under fluoroscopy: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injection (ESI) Page(s): 46.

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

Decision rationale: The request is for epidural steroid injections, which is an injection of a corticosteroid into the epidural space, typically used in the lumbar spine to treat chronic low back pain. It is recommended as an option for treatment of radicular pain. The purpose of ESI 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 offers no significant long-term functional benefit. On average, less than two injections are required for a successful ESI outcome. Current recommendations suggest a second epidural injection if partial success is produced with the first injection, and a third ESI is rarely recommended. Epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. There is little information on improved function. The American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular lumbosacral pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months, and there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain. Criteria for the use of epidural steroid injections include: 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. 8) Current research does not support a series-of-three injections in either the diagnostic or therapeutic phase. The MTUS guidelines recommends no more than 2 ESI injections. The documentation provided stated that the injured worker was previously recommended to have an epidural steroid injection, but was lost to follow up and it was never performed. The treating physician documents the presence of radicular findings on exam, and while the injured worker had received an electrodiagnostic study in the remote past that did not document any radicular findings, there is a more recent MRI that demonstrates discogenic disease that has some consistency with the documented physical exam, but also some inconsistencies (such as numbness throughout entire lower extremities). There is documentation of insufficient relief with NSAIDs and tramadol, as well as physical and chiropractic therapy. Therefore, it does appear that the MTUS guidelines would support the use of epidural steroid injections to one interlaminar level. However, the physician documentation notes profound weakness of the extensor hallucis longus, which is innervated by the L5 nerve root, which exits at the L5-S1 level. Therefore, since only one interlaminar space is recommended for injection at a time, the request for L4-5 epidural steroid injection is not medically necessary at this time. Consideration in the future would require clear documentation of benefit as per MTUS requirements.

ESI at L5-S1 at DMC under fluoroscopy: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injection (ESI) Page(s): 46.

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

Decision rationale: The request is for epidural steroid injections, which is an injection of a corticosteroid into the epidural space, typically used in the lumbar spine to treat chronic low back pain. It is recommended as an option for treatment of radicular pain. The purpose of ESI 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 offers no significant long-term functional benefit. On average, less than two injections are required for a successful ESI outcome. Current recommendations suggest a second epidural injection if partial success is produced with the first injection, and a third ESI is rarely recommended. Epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. There is little information on improved function. The American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular lumbosacral pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months, and there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain. Criteria for the use of epidural steroid injections include: 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. 8) Current research does not support a series-of-three injections in either the diagnostic or therapeutic phase. The MTUS guidelines recommends no more than 2 ESI injections. The documentation provided stated that the injured worker was previously recommended to have an epidural steroid injection, but was lost to follow up and it was never performed. The treating physician documents the presence of radicular findings on exam, and while the injured worker had received an electrodiagnostic study in the remote past that did not document any radicular findings, there is a more recent MRI that demonstrates discogenic disease that has some consistency with the documented physical exam, but also some inconsistencies (such as numbness throughout entire lower extremities). There is documentation of insufficient relief with NSAIDs and tramadol, as well as physical and chiropractic therapy. Therefore, it does appear that the MTUS guidelines would support the use of epidural steroid injections to one interlaminar level. The physician documentation notes profound weakness of the extensor hallucis longus, which is innervated by the L5 nerve root, which exits at the L5-S1 level.

Therefore, since only one interlaminar space is recommended for injection at a time, the request for L5-S1 epidural steroid injection considered medically necessary at this time. Consideration for further ESI in the future would require clear documentation of benefit as per MTUS requirements.

Tramadol 100mg 1 bid times 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 76.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use; Opioids for chronic pain Page(s): 76-80; 80-82.

Decision rationale: The request is for tramadol, which is a synthetic opioid used for the treatment of pain. The chronic use of opioids requires the ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: 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 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. The MTUS guidelines support the chronic use of opioids if the injured worker has returned to work and there is a clear overall improvement in pain and function. The treating physician should consider consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. Consider a psychiatric consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consult if there is evidence of substance misuse. Opioids appear to be efficacious for the treatment of low back pain, but limited for short-term pain relief, and long-term efficacy is unclear (>16 weeks), but also appears limited. Failure to respond to a time-limited course of opioids has led to the suggestion of reassessment and consideration of alternative therapy. In regards to the injured worker, there is documentation of little to no improvement in pain with the use of current medications. There is incomplete fulfillment of the criteria for ongoing use of opioids based upon the MTUS guidelines. Therefore, the request as written is unlikely to provide further benefit to the injured worker and is not medically necessary.

Omeprazole 10mg 1 bid times 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants for pain Page(s): 63.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68.

Decision rationale: The request is for omeprazole, which is a proton pump inhibitor used to treat disorders of the stomach and esophagus. The MTUS guidelines support the use of a proton pump inhibitor in the following circumstances at increased risk for gastrointestinal side effects: (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. Without any risk factors for gastrointestinal disease, there is no clear indication to utilize a proton pump inhibitor in the treatment of an injured worker. The documentation provided does not show the occasional use of NSAIDs, but there is poor support for the ongoing use of NSAIDs, as studies have shown that when non-steroidal anti-inflammatory drugs are used for more than a few weeks, they can retard or impair bone, muscle, and connective tissue healing and perhaps cause hypertension. Furthermore, there is no clear documentation that the injured worker is at increased risk for gastrointestinal disease. The request as written is not supported by the MTUS and is therefore not medically necessary.