

Case Number:	CM15-0132108		
Date Assigned:	07/20/2015	Date of Injury:	06/02/2014
Decision Date:	09/23/2015	UR Denial Date:	07/01/2015
Priority:	Standard	Application Received:	07/08/2015

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: Colorado

Certification(s)/Specialty: Family Practice

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 41 year old male, who sustained an industrial injury on June 2, 2014. He reported low back pain radiating to the left buttock after catching a falling patient while working as an infusion nurse. The injured worker was diagnosed as having lumbar strain/sprain with left lower extremity radicular syndrome, small protrusions and annular tear to the left posterolateral and foraminal aspect of L5-S1 with no significant mass effect and minor facet degeneration and hypertrophy with minimal annular bulging and endplate ridging at the lumbar 4-5 level as supported by magnetic resonance imaging (MRI) on July 22, 2014. Patient is status post left L5-S1 transforaminal epidural steroid injection on September 22, 2014 (which was not effective) and status post L5-S1 discectomy on October 31, 2014. Treatment to date has included diagnostic studies, radiographic imaging, surgical intervention of the lumbar spine, epidural steroid injection, physical therapy, acupuncture, medications and work restrictions. Patient has had PT and acupuncture and medications since surgical intervention. Currently, the injured worker complains of continued low back pain and left buttock and left lower extremity pain with associated tingling and numbness without weakness. He reported no benefit with previous lumbar epidural steroid injection and noted left sacroiliac joint injection made the pain worse. He reported failing trials of Tramadol (drowsiness), Oxycodone (too strong) and Ativan (sleepy). He reported no benefit with acupuncture and little benefit with physical therapy. He reported little benefit with TENS unit use. He rated his pain at 7 on a 1-10 scale with 10 being the worst. Some benefit with surgery, but radicular symptoms ultimately returned. Evaluation on July 9, 2015, revealed an increased pain level since the last visit. He reported his pain with medications is a 7

on a 1-10 scale with 10 being the worst and 10 on a 1-10 scale without medications. Current medications include Gabapentin, Ibuprofen, Flexeril and Tylenol. EMG/NCS of the left lower extremity, Ibuprofen 600 mg #60 and L5-S1 transforaminal epidural steroid injection were requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ibuprofen 600mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Treatments Page(s): 22 and 68.

Decision rationale: Per the MTUS Guidelines, non-steroidal anti-inflammatory drugs are recommended as second line agents for pain, after trial of Acetaminophen, (particularly for those patients at risk for gastrointestinal events, cardiac events, and renal disease), to be taken at the lowest effective dose for shortest period of time. Non-steroidal anti-inflammatory drugs may be first line for moderate to severe pain, based on available evidence, though studies cannot consistently confirm that non-steroidal anti-inflammatory drugs are superior to Acetaminophen. There is no evidence that any of the non-steroidal anti-inflammatory drugs are effective long term for pain relief or functional improvement. There is no consistent evidence that non-steroidal anti-inflammatory drugs are useful for long term management of neuropathic pain. For the patient of concern, the records supplied do not indicate significant improvement in pain with Non-steroidal anti-inflammatory drug as part of his regimen, with pain ratings actually increased at most recent clinic visit noted July 9, 2015. Patient has been taking Ibuprofen for several months at least, maybe longer as needed, and the patient's Ibuprofen dose has recently been decreased. (It is unclear in the records as to why that occurred as patient's pain has not been improved.) There is no objective assessment of function and no indication the medications improved patient's function. Given the lack of evidence, per the Guidelines, to support long term use of non-steroidal anti-inflammatory drugs in pain treatment, and the lack of verifiable improvement in function or pain for this patient with non-steroidal anti-inflammatory drug, the request for Ibuprofen is not medically necessary.

EMG/NCS of the left lower extremity: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, 2ND EDITION 2004, Revised 2011. Chapter 10, pages 807, and 847-848.

Decision rationale: The MTUS Chronic Pain Treatment Guidelines do not address the use of EMG/NCV studies as diagnostics, so the ACOEM Guidelines were consulted. Per the ACOEM Guidelines, electrodiagnostic studies, comprised of EMG and NCV, are recommended when CT or MRI is non-diagnostic and/or patient continues to have symptoms, suggestive of neurological compromise, that do not respond to treatment. However, electrodiagnostic studies are not recommended for patients with chronic low back pain in the absence of "significant" leg pain or numbness. If suspected radicular pain fails to resolve or reaches a plateau after 4-6 weeks, which would allow time to develop new abnormalities on testing, then NCV, with needle EMG component if radiculopathy suspected, would be indicated. NCV would also be indicated if another condition, in addition to or instead of radiculopathy is suspected based on history and/or physical. EMG and/or NCV may also be recommended in situations in which possible neurological compromise may be suspect, but no cause for neurological compromise is present on imaging. Some clinicians would wait to test patients with NCV/EMG until after patient failed a steroid injection as a diagnostic and therapeutic trial. For the patient of concern, there is documentation in most recent clinic note of physical finding of possible neurological compromise with decreased sensation on examination of left lower extremity, and positive straight leg raise test on left. There is no documentation of CT or MRI related to left lower extremity. There is a recent MRI of Lumbar spine which shows disc protrusion into the epidural space which could cause radicular symptoms. There is documentation that conservative measures such as physical therapy, acupuncture, surgery, and medications have been tried and failed regarding to resolve low back and left leg symptoms. As patient has had persistent symptoms despite conservative therapy, EMG/NCV of left lower extremity is medically indicated.

L5-S1 transforaminal epidural steroid injection: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of Epidural steroid injections Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Treatments Page(s): 46.

Decision rationale: Per the MTUS, epidural steroid injections are recommended as an option for treatment of radicular pain. Current guidelines indicate no more than 2 epidural steroid injections are generally needed to achieve some relief of lumbosacral pain, and no evidence suggests relief is lasting. If initial epidural steroid injection does not provide at least 50% reduction in pain as well as some improvement in function, then additional injections are not indicated. Because pain relief is short term and no long term effects on function have been identified, epidural steroid injections are recommended as part of a program including other therapies such as exercise program. There is insufficient evidence to recommend cervical epidural steroid injections to treat cervical radicular pain. Per MTUS Guidelines, the following criteria should be used to determine which patient may benefit from epidural steroid injection: 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 research does not support a “series-of-three” injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections. For the patient of concern, the history includes radicular symptoms and physical findings on examination 7/9/2015 that indicate radiculopathy. There is a recent MRI of Lumbar spine that shows disc protrusion in epidural space around S1 nerve root, which could cause patient's radicular symptoms. (No electrodiagnostic studies are yet available to support radiculopathy as the diagnosis, but the recommendations above require imaging or electrodiagnostics, not necessarily both). Patient has had multiple therapies in the past without relief, including physical therapy, and medications. The patient has had epidural steroid injections in the past that were not helpful, however, those injections were pre-operative. Patient is now post-operative, so clinical picture now is distinct from that clinical picture pre-operatively, and the injection now requested would in practice be considered an initial injection for this clinical scenario. Given that patient has failed conservative therapies, and has findings of radiculopathy on exam as well as possible cause of radiculopathy on imaging, the request for right L5-S1 transforaminal epidural steroid injections is deemed medically necessary.