

Case Number:	CM15-0133443		
Date Assigned:	07/21/2015	Date of Injury:	06/08/1997
Decision Date:	09/25/2015	UR Denial Date:	06/24/2015
Priority:	Standard	Application Received:	07/10/2015

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, District of Columbia, Maryland
 Certification(s)/Specialty: Anesthesiology, Pain Management

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 55-year-old female who sustained an industrial injury on 05/08/97. Initial complaints and diagnoses are not available. Treatments to date include medications and back surgery. Diagnostic studies are not addressed. Current complaints include low back pain and left leg pain. Current diagnoses include chronic lumbar discogenic disease with radiculopathy. In a progress note dated 05/14/15 the treating provider reports the plan of care as continued unspecified medications and home exercise, a back brace and a TENS unit, a MRI of the lumbar spine, lumbar brace, a lumbar epidural steroid injection, and 2 bilateral lumbar spine injections using Toradol and Marcaine. The requested treatments include Neurontin, a back brace and a TENS unit, a MRI of the lumbar spine, lumbar brace, a Lumbar epidural steroid injection, and 2 bilateral lumbar spine injections using Toradol and Marcaine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Neurontin 600mg #90: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs, Gabapentin (Neurontin) Page(s): 16-19.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy Drugs Page(s): 16-18.

Decision rationale: With regard to antiepilepsy drugs, the MTUS CPMTG states "Fibromyalgia: Gabapentin and pregabalin have been found to be safe and efficacious to treat pain and other symptoms. (Arnold, 2007) (Crofford, 2005) Pregabalin is FDA approved for fibromyalgia." Per MTUS CPMTG, "Gabapentin (Neurontin) has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain." Per progress report dated 6/11/15, it was noted that with medications the injured worker is more functional with 70% improvement in her pain and is able to perform daily activities such as house chores, shopping, walking, driving, and Zumba exercises. I respectfully disagree with the UR physician's denial based upon a lack of in-depth neurological examination indicating neuropathic pain etiology. The injured worker is diagnosed with chronic lumbar discogenic disease with radiculopathy and is status post multiple surgeries. The request is medically necessary.

MRI of the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, MRIs (Magnetic resonance imaging).

Decision rationale: Per the ODG guidelines with regard to MRI of the lumbar spine: Recommended for indications below. MRI's are test of choice for patients with prior back surgery, but for uncomplicated low back pain, with radiculopathy, not recommended until after at least one month conservative therapy, sooner if severe or progressive neurologic deficit.

Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (e.g., tumor, infection, fracture, neurocompression, and recurrent disc herniation). (Bigos, 1999) (Mullin, 2000) (ACR, 2000) (AAN, 1994) (Aetna, 2004) (Airaksinen, 2006) (Chou, 2007) Magnetic resonance imaging has also become the mainstay in the evaluation of myelopathy. An important limitation of magnetic resonance imaging in the diagnosis of myelopathy is its high sensitivity. Indications for imaging Magnetic resonance imaging: Thoracic spine trauma: with neurological deficit. Lumbar spine trauma: trauma, neurological deficit. Lumbar spine trauma: seat belt (chance) fracture (If focal, radicular findings or other neurologic deficit). Uncomplicated low back pain, suspicion of cancer, infection, other "red flags". Uncomplicated low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit. Uncomplicated low back pain, prior lumbar surgery. Uncomplicated low back pain, cauda equina syndrome. Myelopathy (neurological deficit related to the spinal cord), traumatic. Myelopathy, painful. Myelopathy, sudden onset. Myelopathy, stepwise progressive. Myelopathy, slowly progressive. Myelopathy, infectious disease patient. Myelopathy, oncology patient. Repeat MRI: When there is significant change in symptoms and/or findings suggestive of significant pathology (e.g., tumor, infection, fracture, neurocompression, recurrent disc herniation) The documentation submitted for review does not contain positive physical examination findings regarding the lumbar spine or indication of subjective complaints of pain to the lumbar spine noted for review that would support the role of an MRI. There are no documented motor, sensory or functional deficits, or aforementioned

indication. The injured worker has previously had lumbar surgery, without evidence of interim change in injured worker's clinical symptoms or positive physical examination findings, an MRI is not supported. The request is not medically necessary.

Lumbar spine brace: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Lumbar supports.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Lumbar supports.

Decision rationale: Per the ODG with regard to lumbar supports: Not recommended for prevention. Recommended as an option for treatment. See below for indications. Prevention: Not recommended for prevention. There is strong and consistent evidence that lumbar supports were not effective in preventing neck and back pain. (Jellema-Cochrane, 2001) (Van Poppel, 1997) (Linton, 2001) (Assendelft-Cochrane, 2004) (Van Poppel, 2004) (Resnick, 2005) Lumbar supports do not prevent LBP. (Kinkade, 2007) A systematic review on preventing episodes of back problems found strong, consistent evidence that exercise interventions are effective and other interventions not effective, including stress management, shoe inserts, back supports, ergonomic/back education, and reduced lifting programs. (Bigos, 2009) This systematic review concluded that there is moderate evidence that lumbar supports are no more effective than doing nothing in preventing low-back pain. (Van Duijvenbode, 2008) Treatment: Recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific LBP (very low quality evidence, but may be a conservative option). As there is only very low-quality evidence supporting the use of back braces for the purpose of treatment, medical necessity cannot be affirmed.

Lumbar epidural steroid injection at L5-S1 bilaterally: Upheld

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

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 research does not support a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections. The documentation submitted for review notes that the injured worker had decreased sensation about the lateral thigh. Motor strength was intact. Imaging studies were not available for review. Above-mentioned citation conveys radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Radiculopathy is defined as two of the following: weakness, sensation deficit, or diminished/ absent reflexes associated with the relevant dermatome. These findings are not documented, so medical necessity is not affirmed. As the first criteria are not met, the request is not medically necessary.

TENS unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy, TENS, chronic pain Page(s): 114-116.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 114-116.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines do not recommend TENS as a primary treatment modality, but support consideration of a one-month home-based TENS trial used as an adjunct to a program of evidence-based functional restoration. Furthermore, criteria for the use of TENS includes pain of at least three months duration, evidence that other appropriate pain modalities have been tried (including medication) and failed, and a documented one-month trial period stating how often the unit was used, as well as outcomes in terms of pain relief and function. The medical records indicate that treatment has included medication management, physical therapy, and surgery. However, there is no documentation of a successful TENS trial. Absent such, the request is not medically necessary.

2 injections to bilateral lumbar spine using Toradol and 3cc Marcaine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

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

Decision rationale: The MTUS is silent on Toradol injection. Per the ODG guidelines with regard to Ketorolac injections, they are not recommended for the lumbar spine, but are recommended in the shoulder chapter: Recommended as an option to corticosteroid injections, with up to three subacromial injections. Avoid use of an oral NSAID at the same time as the injections. Injection of the NSAID Ketorolac shows superiority over corticosteroid injections in the treatment of shoulder pain. As Toradol injection to the lumbar spine is not supported by the guidelines, the request is not medically necessary.