MAXIMUS Federal Services

| Case Number: | CM15-0209145 | | |
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| Date Assigned: | 10/28/2015 | Date of Injury: | 04/03/2006 |
| Decision Date: | 12/11/2015 | UR Denial Date: | 09/21/2015 |
| Priority: | Standard | Application Received: | 10/23/2015 |

## 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: Iowa, Illinois, California
Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive 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 57 year old female, who sustained an industrial injury on 04-03-2006. The injured worker is currently permanent and stationary and working fulltime and full duty. Medical records indicated that the injured worker is undergoing treatment for bilateral L4-L5 radiculopathy, central lumbar focal disc protrusion, central lumbar annular disc bulge, sacroiliac joint pain, lumbar sprain-strain, and lumbar degenerative disc disease. Treatment and diagnostics to date has included bilateral sacroiliac joint injections, left sacroiliac joint radiofrequency nerve ablation, and use of medications. Recent medications have included Ambien, Lidoderm patch, Lyrica, Duexis, and Hydrocodone. Subjective data included tailbone pain (08-07-2015) and bilateral low back pain (07-09-2015 and 09-03-2015). Objective findings (09-03-2015) included restricted lumbar range of motion due to pain, tenderness to palpation to bilateral sacroiliac joints, decreased sensation in the right L5 dermatome of the right leg, and an antalgic gait. The request for authorization dated 09-03-2015 requested a repeat fluoroscopically guided bilateral L4-L5 and bilateral L5-S1 transforaminal epidural steroid injection to treat aggravated low back pain and lower extremity radicular symptoms, a follow up visit, Duexis 800-26.6 1 tablet by mouth three times daily as needed for pain #90 with 1 refill, Lyrica, and Hydrocodone. The Utilization Review with a decision date of 09-21-2015 non-certified the request for repeat fluoroscopically guided bilateral L4-L5 and L5-S1 transforaminal epidural steroid injections and Duexis 800-2.6mg #90 with 1 refill.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Repeat fluoroscopically guided bilateral L4-L5 and L5-S1 transforaminal epidural steroid injection (ESI):** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Methods, and Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Epidural steroid injections (ESIs), therapeutic.

**Decision rationale:** MTUS Chronic pain medical treatment guidelines state that epidural steroid injections are "Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). 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." ACOEM states, "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." MTUS further defines the criteria for epidural steroid injections to 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. (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. Radiculopathy does appear to be documented with imaging studies. Additionally, treatment notes do indicate other conservative treatments were tried and failed (exercises, physical therapy, etc). As such, the request for Repeat fluoroscopically guided bilateral L4-L5 and L5-S1 transforaminal epidural steroid injection (ESI) is medically necessary.

**Duexis 800/26.6mg #90 with 1 refill:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), NSAIDs, GI symptoms & cardiovascular risk and Other Medical Treatment Guidelines Uptodate.com, NSAIDs (including aspirin): Primary prevention of gastroduodenal toxicity.

**Decision rationale:** Duexis is famotidine and ibuprofen. Famotidine is an H2 antagonist used for the treatment of stomach ulcers and gastroesophageal reflux. 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)." Uptodate states regarding H2 antagonist for GI prophylaxis, "Standard doses of H2 receptor antagonists were not effective for the prevention of NSAID-induced gastric ulcers in most reports, although they may prevent duodenal ulcers [33]. Studies that detected a benefit on gastric ulcer prevention were short-term (12 to 24 weeks) and focused on endoscopic rather than clinical endpoints." Medical records do indicate the patient has a history of peptic ulcer disease and of NSAID dyspepsia. As such, the request for Duexis 800/26.6mg #90 with 1 refill is medically necessary.