

Case Number:	CM15-0225060		
Date Assigned:	11/23/2015	Date of Injury:	01/15/2006
Decision Date:	12/31/2015	UR Denial Date:	10/20/2015
Priority:	Standard	Application Received:	11/17/2015

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, Oregon, Washington
 Certification(s)/Specialty: Orthopedic Surgery

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 54 year old female who sustained a work-related injury on 1-15-06. Medical record documentation on 10-7-15 revealed the injured worker was being treated for chronic pain syndrome, lumbago, and lumbar spinal stenosis. She reported low back pain and stated that her pain radiated to the back of both legs past the knee. She reported associated numbness and tingling in the left leg at times. She rated her pain without medications a 3-4 on a 10-point scale and a 2 on a 10-point scale with her medications. Treatment has included Aleve 500 mg, which reduced her pain by 50%, Vicodin, Flexeril, and physical therapy, which provided minimal pain relief. She noted that she received an epidural steroid injection, which provided minimal pain relief. Objective findings included 5-5 bilateral lower extremities strength and negative straight leg raise bilaterally. She had pain with lumbar extension and left lateral bending. She had severe pinpoint tenderness of the left L4-L5 and L5-S1 facet joints and moderate pinpoint tenderness of the right L4-L5 and L5-S1 facet joints. An MRI of the lumbar spine on 8-6-15 revealed L4-5 broad-based disc bulge with facet arthropathy and moderate bilateral foraminal stenosis, and L4-5 pedicle and facet edema suggesting pedicles strain injury and new acute to subacute facet inflammatory changes and L5-S1 facet hypertrophy with mild foraminal narrowing. A request for bilateral (lumbosacral) L4-L5 and L5-S1 medial branch block under fluoroscopy and Flector 1.3% transdermal patch #60 was received on 10-14-15. On 10-20-15, the Utilization Review physician determined bilateral (lumbosacral) L4-L5 and L5-S1 medial branch block under fluoroscopy and Flector 1.3% transdermal patch #60 was not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral (Lumbosacral) L4-L5, L5-S1 medial branch block under fluoroscopy Qty 1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back, Lumbar & Thoracic (Acute & Chronic) - Facet Joint medial branch blocks (therapeutic injections) ; Facet Joint Diagnostic Blocks (injections).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

Decision rationale: According to the CA MTUS Chronic Pain Medical Treatment Guidelines, Epidural injections, page 46, "Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy)." Specifically the guidelines state that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Research has now shown that, 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. 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. In addition there must be demonstration of unresponsiveness to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). CA MTUS criteria for epidural steroid injections are: "Criteria for the use of Epidural steroid injections: Note: 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. 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." In this case, the exam notes from 10/7/15 do not demonstrate a failure of conservative management or a clear evidence of a dermatomal distribution of radiculopathy. Therefore, the proposed epidural steroid injection is not medically necessary and the determination is for non-certification.

Flector 1.3% transdermal patch, Qty 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

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

Decision rationale: CA MTUS/ACOEM is silent on the issue of Flector patch, which is topical Diclofenac. According to the ODG, Pain section, Diclofenac Topical, it is not recommended as a first line treatment but is recommended for patients at risk for GI events from oral NSAIDs. In this case, the exam note from 10/7/15 does not demonstrate prior adverse GI events or intolerance to NSAIDs. Given the lack of documentation of failure of oral NSAIDs or GI events, the prescription is not medically necessary and the determination is for non-certification.