

Case Number:	CM15-0030800		
Date Assigned:	02/24/2015	Date of Injury:	04/20/2007
Decision Date:	04/09/2015	UR Denial Date:	01/16/2015
Priority:	Standard	Application Received:	02/18/2015

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: Physical Medicine & Rehabilitation

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 63 year old male, who sustained an industrial injury on 4/20/2007. He has reported injury to the right knee, low back, neck and bilateral shoulders. He is status post left knee arthroscopy 10/24/2014 and total knee replacement 11/24/14. The diagnoses have included chronic spinal stenosis, left shoulder rotator cuff tear, and internal derangement of bilateral knee, chronic thoracic strain, lumbar radiculopathy and nerve root radiculitis. The medical records submitted for review did not include details regarding prior conservative treatment. Currently, the IW complains of right knee pain, chronic back and neck pain along with shoulder pain. The physical examination from 12/15/14 documented significant abnormal findings of lumbar spine, left knee, left shoulder, and neck. The provider documented pending right knee replacement, pending left shoulder repair, lumbar degenerative disc disease with radicular findings, and cervical discogenic disease with radiculitis. The plan of care included lumbar epidural. On 1/16/2015 Utilization Review non-certified a epidural steroid injection L4-L5 and L5-S1 under fluoroscopy at an outpatient facility and Voltaren Gel 2% four (4) ounces. The MTUS and ODG Guidelines were cited. On 2/18/2015, the injured worker submitted an application for IMR for review of epidural steroid injection L4-L5 and L5-S1 under fluoroscopy at an outpatient facility and Voltaren Gel 2% four (4) ounces.

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-L5 and L5-S1, two visits at an outpatient facility under fluoroscopy: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ESI Page(s): 46-47.

Decision rationale: The patient presents with chronic low back pain with radiating symptoms down the right leg. The request is for EPIDURAL STEROID INJECTION (ESI) AT L4-L5 AND L5-S1, TWO VISITS AT AN OUTPATIENT FACILITY UNDER FLUOROSCOPY. The RFA is not provided. In review of the progress report dated 12/15/14, it was noted that the patient had normal sensation to pinprick and light touch in all dermatomes of the cervical and lumbar. The diagnosis included chronic spinal stenosis, lumbar radiculopathy and nerve root radiculitis. Per progress report dated 12/15/14, the lumbar MRI showed retrolisthesis at L5-S1 and degenerative disc disease at L4-L5 with foraminal stenosis and disk bulging. The patient is currently totally temporarily disabled and has retired. MTUS has the following regarding ESIs, under its chronic pain section: Page 46, 47: "Criteria for the use of Epidural steroid injections: 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 3) Injections should be performed using fluoroscopy (live x-ray) for guidance. 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 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. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. In this case, the patient presents with radicular symptoms down the right leg. However, MRI only shows retrolisthesis at L5-S1 and degenerative disc disease at L4-L5 with foraminal stenosis and disk bulging. Examination was not helpful in diagnosing radiculopathy either. The patient had normal sensation to pinprick and light touch in all dermatomes of the cervical and lumbar. Given the lack of correlation between the patient's radicular symptoms and MRI findings, an ESI would not be indicated. The request IS NOT medically necessary.

Voltaren gel 2% 4oz: 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), Voltaren gel.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesic Anti-inflammatory medications Page(s): 111-113, 22. Decision based on Non-MTUS Citation Official disability guidelines Pain chapter, Diclofenac.

Decision rationale: The patient presents with chronic low back pain with radiating symptoms down the right leg and neck pain along with shoulder pain. The request is for VOLTAREN GEL 2% 4OZ. The RFA is not provided. The diagnosis included chronic spinal stenosis, chronic thoracic strain, lumbar radiculopathy and nerve root radiculitis. The patient is currently totally temporarily disabled and has retired. The MTUS has the following regarding topical creams (p111, chronic pain section): "Topical Analgesics: Recommended as an option as indicated below. Non-steroidal anti-inflammatory agents (NSAIDs): The efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period." Guidelines also do not support the use of topical NSAIDs such as Voltaren for axial, spinal pain, but supports its use for peripheral joint arthritis and tendinitis. MTUS Chronic Pain Medical Treatment Guidelines, pg 22 for Anti-inflammatory medications states: Anti-inflammatory are the traditional first line of treatment, to reduce pain so activity and functional restoration can resume, but long-term use may not be warranted. However, for Diclofenac, ODG guidelines provide a specific discussion stating, "Not recommended as first line due to increased risk profile. A large systematic review of available evidence on NSAIDs confirms that diclofenac, a widely used NSAID, poses an equivalent risk of cardiovascular events to patients as did rofecoxib (Vioxx), which was taken off the market. According to the authors, this is a significant issue and doctors should avoid diclofenac because it increases the risk by about 40%." It goes onto state that there is substantial increase in stroke. In this case, the first documentation of Voltaren gel is noted in the progress report dated 12/15/14. The patient suffers from chronic neck and low back pain and treater is requesting Voltaren for application to the neck and the lumbar spine. Guidelines also do not support the use of topical NSAIDs such as Voltaren for axial, spinal pain, but supports its use for peripheral joint arthritis and tendinitis. In this case, the patient does not present with indication for use of this medication, peripheral joint arthritis/tendinitis. Furthermore, ODG does not support this medication unless other NSAIDs have failed and the patient is a very low risk profile. Review of the progress report provided, does not indicate whether or not the patient has utilized other NSAIDs. The request IS NOT medically necessary.