

Case Number:	CM15-0058009		
Date Assigned:	04/02/2015	Date of Injury:	06/14/2011
Decision Date:	05/06/2015	UR Denial Date:	02/27/2015
Priority:	Standard	Application Received:	03/26/2015

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: Indiana

Certification(s)/Specialty: Preventive Medicine, Occupational 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 60 year old male, who sustained an industrial injury on 06/14/2011. The injured worker is currently diagnosed as having lumbar spine disc herniation, lumbar radiculopathy, thoracic spine compression fractures, and thoracic spine multilevel degenerative disc disease. Treatment to date has included leg surgeries, epidural steroid injections, lumbar and thoracic MRIs, and medications. In a progress note dated 02/12/2015, the injured worker presented with complaints of back, neck, and bilateral shoulder pain. The treating physician reported requesting authorization for transforaminal epidural injection on the right at L4 and L5 and Omeprazole.

IMR ISSUES, DECISIONS AND RATIONALES

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

One transforaminal epidural steroid injection at right L4-L5: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines epidural steroid injections Page(s): 46. Decision

based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Facet joint diagnostic blocks (injections), Epidural steroid injections (ESIs), therapeutic Other Medical Treatment Guideline or Medical Evidence: MD Guidelines, Facet Joint Injections/Therapeutic Facet Joint Injections.

Decision rationale: ACOEM Guidelines state "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." ODG and MD Guidelines agree that: "One diagnostic facet joint injection may be recommended for patients with chronic low back pain that is significantly exacerbated by extension and rotation or associated with lumbar rigidity and not alleviated with other conservative treatments (e.g., NSAIDs, aerobic exercise, other exercise, manipulation) in order to determine whether specific interventions targeting the facet joint are recommended. If after the initial block/blocks are given (see 'Diagnostic Phase' above) and found to produce pain relief of at least 50-70% pain relief for at least 6-8 weeks, additional blocks may be supported." Treating physician does not document at least 50% pain relief. The treating physician writes that the "medication and injections have helped alleviate the pain somewhat", but does not quantify the level of relief. Per ODG, "Indications for repeat blocks include acute exacerbation of pain, or new onset of radicular symptoms. Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response." The treating physician does not document any acute exacerbation of pain, new radicular symptoms, continued objective pain relief, or functional response. As such, the request is not medically necessary.

One prescription of Omeprazole 20 mg, 120 count: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS; GI risk Page(s): 68-69. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), NSAIDs, GI symptoms & cardiovascular risk.

Decision rationale: 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)." ODG states "If a PPI is used, omeprazole OTC tablets or lansoprazole 24HR OTC are recommended for an equivalent clinical efficacy and significant cost savings. Products in this drug class have demonstrated equivalent clinical efficacy and safety at comparable doses, including esomeprazole (Nexium), lansoprazole (Prevacid), omeprazole (Prilosec), pantoprazole (Protonix), dexlansoprazole (Dexilant), and rabeprazole (Aciphex). (Shi, 2008) A trial of omeprazole or lansoprazole is recommended before Nexium therapy. The other PPIs, Protonix, Dexilant, and Aciphex, should also be second-line. According to the latest AHRQ

Comparative Effectiveness Research, all of the commercially available PPIs appeared to be similarly effective. (AHRQ, 2011)." The medical documents provided do not establish the patient has having documented GI bleeding, perforation, peptic ulcer, high dose NSAID, or other GI risk factors as outlined in MTUS. As such, the request for is not medically necessary.