

Case Number:	CM14-0095398		
Date Assigned:	09/22/2014	Date of Injury:	09/18/1984
Decision Date:	10/21/2014	UR Denial Date:	06/13/2014
Priority:	Standard	Application Received:	06/23/2014

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. The expert reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

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

According to the records made available for review, this is a 60-year-old female with a 9/18/84 date of injury. At the time (5/29/14) of request for authorization for Transforaminal Epidural Steroid Injection L3-4, Genicin 500mg #90, and Flurbi Cream, there is documentation of subjective (low back pain and bilateral lower extremity radicular pain) and objective (decreased lumbar spine range of motion, sensation intact, and 5/5 motor strength) findings, current diagnoses (lumbar disc disease, lumbar radiculitis, and post laminectomy syndrome), and treatment to date (medications (including ongoing treatment with Norco, topical cream, Anaprox, Gabapentin, and Prilosec) and acupuncture treatment). Regarding Transforaminal Epidural Steroid Injection L3-4, there is no documentation of subjective (pain, numbness, or tingling) and objective (sensory changes, motor changes, or reflex changes) radicular findings in the requested nerve root distributions, and imaging (MRI, CT, myelography, or CT myelography & x-ray) findings (nerve root compression OR moderate or greater central canal stenosis, lateral recess stenosis, or neural foraminal stenosis) at the requested levels. Regarding Genicin, there is no documentation of moderate arthritis pain; and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Glucosamine use to date. Regarding Flurbi Cream, there is no documentation of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist); short-term use (4-12 weeks); failure of an oral NSAID or contraindications to oral NSAIDs; and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Flurbi Cream use to date.

IMR ISSUES, DECISIONS AND RATIONALES

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

Transforaminal Epidural Steroid Injection L3-4: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection (ESI).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Epidural Steroid Injections (ESIs)

Decision rationale: MTUS reference to ACOEM guidelines identifies documentations of objective radiculopathy in an effort to avoid surgery as criteria necessary to support the medical necessity of epidural steroid injections. ODG identifies documentation of subjective (pain, numbness, or tingling in a correlating nerve root distribution) and objective (sensory changes, motor changes, or reflex changes (if reflex relevant to the associated level) in a correlating nerve root distribution) radicular findings in each of the requested nerve root distributions, imaging (MRI, CT, myelography, or CT myelography & x-ray) findings (nerve root compression OR moderate or greater central canal stenosis, lateral recess stenosis, or neural foraminal stenosis) at each of the requested levels, failure of conservative treatment (activity modification, medications, and physical modalities), and no more than two nerve root levels injected one session; as criteria necessary to support the medical necessity of lumbar epidural steroid injection. Within the medical information available for review, there is documentation of diagnoses of lumbar disc disease, lumbar radiculitis, and post laminectomy syndrome. In addition, there is documentation of failure of conservative treatment (activity modification, medications, and physical modalities). However, despite non-specific documentation of subjective findings (low back pain and bilateral lower extremity radicular pain), there is no specific (to a nerve root distribution) documentation of subjective (pain, numbness, or tingling) radicular findings in the requested nerve root distributions. In addition, given documentation of objective findings (sensation intact and 5/5 motor strength), there is no documentation of objective (sensory changes, motor changes, or reflex changes) radicular findings in the requested nerve root distributions. Furthermore, there is no documentation of imaging (MRI, CT, myelography, or CT myelography & x-ray) findings (nerve root compression OR moderate or greater central canal stenosis, lateral recess stenosis, or neural foraminal stenosis) at the requested levels. Therefore, based on guidelines and a review of the evidence, the request for Transforaminal Epidural Steroid Injection L3-4 is not medically necessary.

Genicin 500mg #90: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Glucosamine (and Chondroitin Sulfate) Page(s): 50. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of moderate arthritis pain as criteria necessary to support the medical necessity of Genicin. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of lumbar disc disease, lumbar radiculitis, and post laminectomy syndrome. In addition, there is documentation of ongoing treatment of Glucosamine. However, there is no documentation of moderate arthritis pain. In addition, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Glucosamine use to date. Therefore, based on guidelines and a review of the evidence, the request for Genicin 500mg #90 is not medically necessary.

Flurbi Cream: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non-steroidal anti-inflammatory agents (NSAIDs) Page(s): 111-112. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Topical analgesics Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist) and short-term use (4-12 weeks), as criteria necessary to support the medical necessity of topical NSAIDs. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies documentation of failure of an oral NSAID or contraindications to oral NSAIDs. Within the medical information available for review, there is documentation of diagnoses of lumbar disc disease, lumbar radiculitis, and post laminectomy syndrome. In addition, there is documentation of ongoing treatment with topical cream. However, there is no documentation of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). In addition, given documentation of ongoing treatment with topical cream, there is no documentation of short-term use (4-12 weeks). Furthermore, there is no documentation of failure of an oral NSAID or contraindications to oral NSAIDs. Lastly, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Flurbi Cream use to date. Therefore, based on guidelines and a review of the evidence, the request for Flurbi Cream is not medically necessary.