

Case Number:	CM15-0111577		
Date Assigned:	07/21/2015	Date of Injury:	12/24/2001
Decision Date:	08/26/2015	UR Denial Date:	05/16/2015
Priority:	Standard	Application Received:	06/09/2015

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, District of Columbia, Maryland
 Certification(s)/Specialty: Anesthesiology, Pain Management

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 53 year old male, who sustained an industrial injury on 12/24/2001. He reported falling sixteen feet. Diagnoses have included bilateral carpal tunnel syndrome status post carpal tunnel release, left sacroiliac sprain-strain, lumbar discopathy with disc displacement status post microdiscectomy, cervical discopathy with disc displacement and cervical headaches. Treatment to date has included physical therapy, massage therapy, chiropractic treatment and medication. According to the progress report dated 4/23/2015, the injured worker complained of low back pain and neck pain. He was status post epidural steroid injection to the neck and low back. He did not note any improvement in his symptomatology. He complained of numbness and tingling in both hands. Medications were helpful in alleviating pain. Exam of the cervical spine revealed tenderness to palpation and decreased range of motion. Spurling's sign was positive bilaterally. There was decreased sensation in the median nerve distribution of the bilateral hands. Exam of the lumbar spine revealed tenderness to palpation and decreased range of motion. Supine straight leg raise was positive bilaterally. There was spasm in the lumbar paraspinal musculature. Authorization was requested for three lumbar epidural steroid injections, three cervical epidural steroid injections, Nalfon and Fioricet.

IMR ISSUES, DECISIONS AND RATIONALES

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

3 lumbar epidural steroid injections: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections, Criteria for the use of Epidural steroid injections.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46.

Decision rationale: Per the MTUS CPMTG epidural steroid injections are used 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 benefit. The criteria for the use of epidural steroid injections are as follows: 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. Per the documentation submitted for review, the injured worker had positive straight leg raising test bilaterally at 20', decreased sensation to light touch and pin prick in bilateral L5/S1 distribution. Imaging studies were not available for review. Above mentioned citation conveys radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Radiculopathy is defined as two of the following: weakness, sensation deficit, or diminished/absent reflexes associated with the relevant dermatome. These findings are not documented, so medical necessity is not affirmed. Furthermore, it is noted that the injured worker underwent lumbar epidural steroid injection at L5-S1 on 4/15/15. There was no documentation of the result of this injection. As the first criteria is not met, and there is no documentation supporting repeat injection, the request is not medically necessary.

3 cervical epidural steroid injections: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections, Criteria for the use of Epidural steroid injections.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46.

Decision rationale: Per the MTUS CPMTG epidural steroid injections are used 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 benefit. The criteria for the use of epidural steroid injections are as follows: 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. The documentation submitted for review notes that the injured worker had numbness and tingling in the upper extremities, status post bilateral carpal tunnel release. It was also noted there was decreased sensation in the median nerve distribution as well as C5-C6. MRI of the cervical spine dated 1/8/14 revealed no significant degenerative changes within the cervical spine. The spinal canal and bilateral neural foramina were patent throughout. Above mentioned citation conveys radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Radiculopathy is defined as two of the following: weakness, sensation deficit, or diminished/absent reflexes associated with the relevant dermatome. These findings are not documented, so medical necessity is not affirmed. As the first criteria is not met, the request is not medically necessary. Furthermore, the guidelines do not support a series-of-three injections.

Nalfon 400mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Fenoprofen (Nalfon), NSAIDs (non-steroidal anti-inflammatory drugs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-68.

Decision rationale: With regard to the use of NSAIDs for chronic low back pain, the MTUS CPMTG states "Recommended as an option for short-term symptomatic relief. A Cochrane review of the literature on drug relief for low back pain (LBP) suggested that NSAIDs were no more effective than other drugs such as acetaminophen, narcotic analgesics, and muscle relaxants. The review also found that NSAIDs had more adverse effects than placebo and acetaminophen but fewer effects than muscle relaxants and narcotic analgesics. In addition, evidence from the review suggested that no one NSAID, including COX-2 inhibitors, was clearly more effective than another." "Low back pain (chronic): Both acetaminophen and NSAIDs have been recommended as first line therapy for low back pain. There is insufficient

evidence to recommend one medication over the other. Selection should be made on a case-by-case basis based on weighing efficacy vs. side effect profile." The documentation submitted for review does not indicate why this medication is prescribed instead of first-line NSAIDs such as naproxen or ibuprofen. The documentation submitted for review indicates that the injured worker has using this medication since at least 9/2014. As NSAIDs are only recommended for short-term symptomatic relief, the request is not medically necessary.

Fioricet (Butalbital/APAP/Caffeine) 50/325/40mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Barbiturate-containing analgesic agents.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Barbiturate-containing analgesic agents Page(s): 23.

Decision rationale: Per MTUS CPMTG with regard to barbiturate-containing analgesic agents: "Not recommended for chronic pain. The potential for drug dependence is high and no evidence exists to show a clinically important enhancement of analgesic efficacy of BCAs due to the barbiturate constituents. (McLean, 2000) There is a risk of medication overuse as well as rebound headache." As the request is not recommended by the MTUS, the request is not medically necessary. It should be noted that the UR physician has certified a modification of the request for the purpose of weaning.