

Case Number:	CM15-0114378		
Date Assigned:	06/22/2015	Date of Injury:	06/26/2014
Decision Date:	07/21/2015	UR Denial Date:	06/01/2015
Priority:	Standard	Application Received:	06/12/2015

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: New Jersey

Certification(s)/Specialty: Family Practice

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 52-year-old female, who sustained an industrial injury on 6/26/2014. She reported pain in her buttocks, lower back and right leg due to falling. Diagnoses have included lumbar spine stenosis (magnetic resonance imaging (MRI) evidence of mild, spinal canal stenosis at L3-L4, L5-S1 and moderate spinal canal stenosis at L4-L5 level, 10/29/2014), lumbar spine radiculopathy and lumbar spine herniated nucleus pulposus (HNP) (magnetic resonance imaging (MRI) evidence of multilevel diffuse posterior disc bulge with osteophyte complex, 10/29/2014). Treatment to date has included physical therapy, aqua therapy and medication. According to the progress report dated 5/14/2015, the injured worker complained of intermittent moderate low back pain with tingling and numbness, as well as a sharp sensation down the left leg to the toes. She had one epidural steroid injection, which provided relief for four to five days. Exam of the lumbar spine revealed increased tone and tenderness. There were muscle spasms. Straight leg raise was positive bilaterally. The injured worker was given a prescription for Naproxen. Authorization was requested for a second epidural steroid injection at L5-S1 and Omeprazole.

IMR ISSUES, DECISIONS AND RATIONALES

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

2CD Epidural Steroid Injection, L5-S1: 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 Epidural steroid injections, p. 46.

Decision rationale: The MTUS Guidelines state that epidural steroid injections are recommended as an option for treatment of lumbar radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy) and can offer short-term pain relief, but use should be in conjunction with other rehab efforts, including continuing a home exercise program. The criteria as stated in the MTUS Guidelines for epidural steroid injection use for chronic pain includes the following: 1. radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing, 2. Initially unresponsive to conservative treatment (exercise, physical methods, NSAIDs, and muscle relaxants), 3. Injections should be performed using fluoroscopy 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, and 8. Current research does not support "series-of-three" injections in either the diagnostic or the therapeutic phase, and instead only up to 2 injections are recommended. In the case of this worker, recent documentation reported low back pain with radiation to the legs with numbness and tingling with a positive straight leg raise test bilaterally and decreased sensation of the left L5-S1 dermatomes. MRI from 2014 showed mild spinal canal stenosis at the L5-S1 level. She had completed a previous steroid epidural injection one month prior, which had helped relieve her pain for only 4-5 days, as was documented in the notes provided. Although, there was some evidence of radiculopathy of the L5-S1 level, due to the failure of the prior L5-S1 injection providing relief for a long enough duration of time to justify a repeat injection of that area. Therefore, the request for the second epidural steroid injection of the L5-S1 will be considered medically unnecessary.

Omeprazole capsule 20mg #60 for 30 days: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Prilosec (omeprazole).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines GI symptoms & cardiovascular risk, pp. 68-69.

Decision rationale: The MTUS Guidelines state that to warrant using a proton pump inhibitor (PPI) in conjunction with an NSAID, the patient would need to display intermediate or high risk for developing a gastrointestinal event such as those older than 65 years old, those with a history

of peptic ulcer, GI bleeding, or perforation, or those taking concurrently aspirin, corticosteroids, and/or an anticoagulant, or those taking a high dose or multiple NSAIDs. In the case of this worker, there was no significant medical history or signs/symptoms to suggest they were at a higher risk for gastrointestinal events to warrant chronic PPI use as was prescribed to this worker. Therefore, the omeprazole will be considered medically unnecessary without this supportive data or a clear indication.