

Case Number:	CM15-0116287		
Date Assigned:	06/30/2015	Date of Injury:	09/08/2003
Decision Date:	09/28/2015	UR Denial Date:	06/02/2015
Priority:	Standard	Application Received:	06/16/2015

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: Emergency 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 53 year old female who sustained an industrial injury on 9/8/03 after falling and twisting her ankle. She felt a sudden onset of ankle pain after falling. Later that day she developed low back pain. She was medically evaluated and initially treated with physical therapy, lumbar epidural steroid injections, transcutaneous electrical nerve stimulator unit. She currently complains of moderate to severe constant low back pain and left greater than right lower extremity radicular pain. Her pain level is 4/10 and pain does interfere with her sleep. On physical exam she was tender on palpation over the left greater than right lumbar paraspinals with decreased range of motion. Medications are Soma, Norco, and Sonata. Diagnoses include right L5-S1 laminectomy and Discectomy (1/17/06, 7/21/08); removal of pedicle screw instrumentation (4/19/10); lumbar disc disease; lumbar radiculitis; post laminectomy syndrome; sacroiliitis. Treatments to date include transforaminal epidural steroid injection (12/12/06); spinal cord stimulator trial (2/12/07); lumbar epidural steroid injection with 50% relief greater than eight weeks (2011 and 1/10/12, 7/2/12, 2/2013) with significant relief of pain. Diagnostics include electromyography (7/30/12) chronic bilateral radiculopathy (L5-S1 without acute denervation; electromyography (6/1/09) abnormal; MRI of the lumbar spine (1/31/11) showing degenerative disc disease; computed tomography of the lumbar spine (4/8/09) showing L5-S1 posterior lateral fusion. In the progress note dated 5/14/15 the treating provider's plan of care included requests for transforaminal epidural steroid injection bilateral at L3-4; computed tomography of the lumbar spine to rule out stenosis; electromyography/ nerve conduction study of bilateral lower extremities to rule out radiculopathy; Norco 10-325 mg #120; Flexeril 7.5 mg #

60; Terocin Patches # 30; Terocin 240 milliliter cream; Genicin 500 mg # 90; flurbi (NAP) cream-LA 180 grams. The provider noted that the injured worker was not improving.

IMR ISSUES, DECISIONS AND RATIONALES

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

CT scan of the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back (Lumbar and Thoracic) Computed Tomography.

Decision rationale: The request is for a Lumbar CT scan. The ODG states the following regarding this topic: Indications for imaging--Computed tomography: Thoracic spine trauma: equivocal or positive plain films, no neurological deficit, Thoracic spine trauma: with neurological deficit, Lumbar spine trauma: trauma, neurological deficit, Lumbar spine trauma: seat belt (chance) fracture, Myelopathy (neurological deficit related to the spinal cord), traumatic, Myelopathy, infectious disease patient, Evaluate pars defect not identified on plain x-rays, Evaluate successful fusion if plain x-rays do not confirm fusion. (Laasonen, 1989) In this case, this study is not indicated. As stated above, qualifying factors would include new neurologic deficits after trauma. There is inadequate documentation to support the above criteria. As such, the request is not medically necessary.

EMG/NCS of the bilateral lower extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 177-179.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) EMGs (electromyography).

Decision rationale: Recommended as an option (needle, not surface). EMGs (electromyography) may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. (Bigos, 1999) (Ortiz-Corredor, 2003) (Haig, 2005) No correlation was found between intraoperative EMG findings and immediate postoperative pain, but intraoperative spinal cord monitoring is becoming more common and there may be benefit in surgery with major corrective anatomic intervention like fracture or scoliosis or fusion where there is significant stenosis. (Dimopoulos, 2004) EMG's may be required by the AMA Guides for an impairment rating of radiculopathy. (AMA, 2001) (Note: Needle EMG and H-reflex tests are recommended, but Surface EMG and F-wave tests are not very specific and therefore are not recommended. See Surface electromyography.) In this case, the patient does not meet criteria for the study requested. This is secondary to radiculopathy already diagnosed in the records. Pending receipt

of information further clarifying how this would change the management rendered, the study is not medically necessary.

Transforaminal epidural steroid injection at L3-4: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46 of 127.

Decision rationale: The request is for an epidural steroid injection to aid in pain relief. There are certain qualifying criteria regarding the use of this treatment modality. The MTUS guidelines state the following on this topic: Criteria for the use of Epidural steroid injections: Note: The purpose of ESI is 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 functional benefit. 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electro-diagnostic 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. In this case, the patient does not meet the criteria set above. This is secondary to the number of previous ESI, as no more the 2 are advised. As such, the request is not medically necessary.

Norco 10/325mg #120 with two refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78 of 127.

Decision rationale: The request is for the use of a medication in the opioid class. The MTUS guidelines state that for ongoing treatment with a pharmaceutical in this class, certain requirements are necessary. This includes not only adequate pain control, but also functional improvement. Four domains have been proposed for management of patients on opioids. This

includes pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant drug-related behaviors. In this case, there is inadequate documentation of persistent functional improvement which should eventually lead to medication discontinuation. As such, the request is not medically necessary. All opioid medications should be titrated down slowly in order to prevent a significant withdrawal syndrome.

Flexeril 7.5mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63 of 127.

Decision rationale: The request is for the use of a muscle relaxant to aid in pain relief. The MTUS guidelines state that the use of a medication in this class is indicated as a second-line option for short-term treatment of acute exacerbations of low back pain. Muscle relaxants may be effective in reducing pain and muscle tension, which can increase mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain improvement. Efficacy appears to diminish over time, and prolonged use may lead to dependence. (Homik, 2004) Due to inadequate qualifying evidence and prolonged duration of use, the request is not medically necessary. All muscle relaxant medications should be titrated down slowly to prevent an acute withdrawal syndrome.

Terocin Patches #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111 to 113 of 127.

Decision rationale: The request is for the use of a compounded medication for topical use to aid in pain relief. These products contain multiple ingredients which each have specific properties and mechanisms of action. The MTUS guidelines state the following: "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." In this case, the compounded topical treatment contains an NSAID. Qualifying factors for this product is indicated by the following per the guidelines: 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. (Lin, 2004) (Bjordal, 2007) (Mason, 2004) When investigated specifically for osteoarthritis of the knee, topical NSAIDs have been shown to be superior to placebo for 4 to 12 weeks. Indications: Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis

of the spine, hip or shoulder. FDA-approved agents: Voltaren Gel 1% (diclofenac): Indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder. In this case, as stated above, the patient would not qualify for the use of a topical NSAID. This is based on the diagnosis and treatment duration. As such, the request is not medically necessary.

Terocin 240ml 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 Page(s): 111 to 113 of 127.

Decision rationale: The request is for the use of a compounded medication for topical use to aid in pain relief. These products contain multiple ingredients which each have specific properties and mechanisms of action. The MTUS guidelines state the following: "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." In this case, the compounded topical treatment contains an NSAID. Qualifying factors for this product is indicated by the following per the guidelines: 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. (Lin, 2004) (Bjordal, 2007) (Mason, 2004) When investigated specifically for osteoarthritis of the knee, topical NSAIDs have been shown to be superior to placebo for 4 to 12 weeks. Indications: Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. FDA-approved agents: Voltaren Gel 1% (diclofenac): Indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder. In this case, as stated above, the patient would not qualify for the use of a topical NSAID. This is based on the diagnosis and treatment duration. As such, the request 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 Page(s): 50 of 127.

Decision rationale: The request is for the use of glucosamine for pain relief. The MTUS guidelines state the following regarding this topic: Recommended as an option given its low risk, in patients with moderate arthritis pain, especially for knee osteoarthritis. Studies have demonstrated a highly significant efficacy for crystalline glucosamine sulphate (GS) on all

outcomes, including joint space narrowing, pain, mobility, safety, and response to treatment, but similar studies are lacking for glucosamine hydrochloride (GH). (Richy, 2003) (Ruane, 2002) (Towheed-Cochrane, 2001) (Braham, 2003) (Reginster, 2007) A randomized, double blind placebo controlled trial, with 212 patients, found that patients on placebo had progressive joint- space narrowing, but there was no significant joint-space loss in patients on glucosamine sulphate. In this case, the use of glucosamine is not indicated. The patient does not meet the diagnostic criteria set for use. As such, the request is not medically necessary.

Flubri (NAP) cream LA 180gm: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111 to 113 of 127.

Decision rationale: The request is for the use of a compounded medication for topical use to aid in pain relief. These products contain multiple ingredients which each have specific properties and mechanisms of action. The MTUS guidelines state the following: "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." In this case, the compounded topical treatment contains an NSAID. Qualifying factors for this product is indicated by the following per the guidelines: 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. (Lin, 2004) (Bjordal, 2007) (Mason, 2004) When investigated specifically for osteoarthritis of the knee, topical NSAIDs have been shown to be superior to placebo for 4 to 12 weeks. Indications: Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. FDA-approved agents: Voltaren Gel 1% (diclofenac): Indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder. In this case, as stated above, the patient would not qualify for the use of a topical NSAID. This is based on the diagnosis and treatment duration. As such, the request is not medically necessary.