

<b>Case Number:</b>	CM15-0074437		
<b>Date Assigned:</b>	04/24/2015	<b>Date of Injury:</b>	05/08/2013
<b>Decision Date:</b>	05/22/2015	<b>UR Denial Date:</b>	04/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/20/2015

### 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: Maryland

Certification(s)/Specialty: Internal Medicine, Rheumatology

### 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 30-year-old male, who sustained an industrial injury on 5/08/2013. He reported walking, stepping into a hole with his left foot, and grabbing a nearby vine to prevent from falling. The injured worker was diagnosed as having lumbar radiculopathy, lumbar facet arthropathy, and lumbar herniated nucleus pulposus. Treatment to date has included diagnostics, acupuncture, chiropractic, physical therapy (with electrical stimulation per Agreed Medical Examination dated 1/28/2015), and medications. Currently, the injured worker complains of low back pain with symptoms into the left lower extremity, rated 4/10. He reported increased pain when working, although it is noted he last worked on 2/25/2015. His work status was Temporary Partial Disability. Current medications included Gabapentin, Naproxen, and Prilosec. Over the counter anti-inflammatory medications were documented to provide minimal relief and cause gastrointestinal upset. Magnetic resonance imaging of the lumbar spine, dated 8/02/2013, was referenced. Electromyogram and nerve conduction studies of the lower extremities from 11/22/2013 were referenced. The treatment plan included transforaminal epidural steroid injection at the left L5 and S1 nerve roots, transcutaneous electrical nerve stimulation unit for home use, and medication refills.

### IMR ISSUES, DECISIONS AND RATIONALES

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

## **1 Transforaminal Epidural Steroid Injection at the Left L5 and S1: 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 Epidural steroid injections Page(s): 46.

**Decision rationale:** This 30 year old male has complained of low back pain since date of injury 5/8/13. He has been treated with acupuncture, chiropractic therapy and medications. The current request is for 1 transforaminal epidural steroid injection at the left L5 and S1. Per the MTUS guidelines cited above epidural corticosteroid injections are recommended as an option for the treatment of radicular pain when the specific following criteria are met: 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 available medical records do not include documentation that criteria (1) above has been met. Specifically, the available provider notes do not document evidence of radiculopathy by physical examination that is corroborated by imaging studies and/or electrodiagnostic testing. On the basis of the MTUS guidelines, 1 transforaminal epidural steroid injection at the left L5 and S1 is not indicated as medically necessary.

## **1 Transcutaneous Electrical Nerve Stimulator Unit with Supplies: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 114-116.

**Decision rationale:** This 30 year old male has complained of low back pain since date of injury 5/8/13. He has been treated with acupuncture, chiropractic therapy and medications. The current request is for 1 transcutaneous electrical nerve stimulator unit with supplies. Per the MTUS guideline cited above, a 1 month trial of TENS unit therapy should be documented including documentation of how often the TENS unit was used as well as outcomes in terms of pain relief and function with use of the TENS unit. The available medical records included for review do not include this documentation. On the basis of the cited MTUS guideline and the lack of documentation, a TENS unit is not indicated as medically necessary.

**60 Capsules of Omeprazole 20 Mg: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI symptoms and cardiovascular risk.

**Decision rationale:** This 30 year old male has complained of low back pain since date of injury 5/8/13. He has been treated with acupuncture, chiropractic therapy and medications. The current request is for Prilosec. No treating physician reports adequately describe the relevant signs and symptoms of possible GI disease. No reports describe the specific risk factors for GI disease in this patient. In the MTUS citation listed above, chronic use of PPI's can predispose patients to hip fractures and other unwanted side effects such as Clostridium difficile colitis. Based on the MTUS guidelines cited above and the lack of medical documentation, Prilosec is not medically necessary in this patient.