

<b>Case Number:</b>	CM13-0039167		
<b>Date Assigned:</b>	12/18/2013	<b>Date of Injury:</b>	01/12/2004
<b>Decision Date:</b>	03/12/2014	<b>UR Denial Date:</b>	10/01/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/03/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, 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 least at 24 hours a week in active practice. The physician 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:

The patient is a 52 year old female with a date of injury of 11/12/2004. The listed diagnoses per [REDACTED] dated 08/30/2013 are: 1. Degenerative disc disease, lumbar 2. Upper back pain 3. Neck pain 4. Chronic headaches According to report dated 08/30/2013 by [REDACTED], patient presents with chronic lumbar spine pain, which radiates down the posterior aspect of the left lower extremity to the bottom of the foot. The patient is also complaining of neck pain, right knee pain and headaches. The treating physician notes the patient has had "four prior back surgeries", however the date of prior surgeries are unnoted. Examination of the lumbar spine showed reduced decrease in range of motion and positive straight leg raise on the left at 45 degrees. Sensory deficit to light touch in the left lower extremity was also noted. MRI of the lumbar spine dated 03/15/2012 show L3-4 minimal broad -based disc bulge with left lateral disc protrusion and mild caudal left neuroforaminal narrowing, L4-5 post surgical changes with facet arthropathy, mild left neuroforaminal narrowing with no central stenosis, and post operative changes at L5-S1 with no evidence of stenosis.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Transforaminal epidural steroid injection left L3, L4:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM,Chronic Pain Treatment Guidelines ESI, lumbar. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**Decision rationale:** This patient presents with chronic lumbar spine pain, which radiates down the posterior aspect of the left lower extremity to the bottom of the foot. Treating physician is requesting a transforaminal epidural steroid injection to the left L3, L4. The utilization review dated 10/01/2013 denied the request stating "lack of reduction in pain and functional improvement from prior injection dated 08/02/2013." I reviewed reports from 08/02/2013, prior and subsequent reports dated 06/20/2013, 07/31/2013, 08/16/2013, 08/30/2013, and 09/27/2013, as well as Agreed Medical Evaluator (AME) report from 02/14/2013. None of the reports provided for review discuss any prior epidural injections. In fact the report dated 08/02/2013, states "I am recommending and the patient desires a bilateral L4/5 and left L5/S1." I am unable to verify any prior injections and their results. MTUS guidelines recommend ESI when radiculopathy is documented via examination and imaging studies. In this case, the treating physician indicates the patient has left leg pain. However, the location of pain is through posterior thigh/calf, which is S1 nerve distribution. The treating physician is requesting L3 and L4 level injections to coincide with lateral bulge at L3-4. The patient does not present with dermatomal distribution of pain that would corroborate the MRI findings. Recommendation is for denial.

**Voltaren gel 1% 5 tubes apply 4x per day:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines topical creams Page(s): 111.

**Decision rationale:** This patient presents with chronic lumbar spine pain, which radiates down the posterior aspect of the left lower extremity to the bottom of the foot. Treating physician is requesting Voltaren gel. MTUS guidelines state the "efficacy in clinical trials for this topical NSAID modality has been inconsistent and most studies are small and of short duration. Indications are for 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. As indicated in the provided medical reports, the patient's complaints are of low and upper back pain. The patient does not suffer from peripheral joint arthritis or tendinitis problems for which topical NSAIDs are indicated. The requested Voltaren gel is not medically necessary and recommendation is for denial.

**Lidoderm patches 5%, #90:**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines lidoderm patches Page(s): s 56-57.

**Decision rationale:** This patient presents with chronic lumbar spine pain, which radiates down the posterior aspect of the left lower extremity to the bottom of the foot. Treating physician is requesting Lidoderm patches. The MTUS guidelines page 112 under Lidocaine state indications are for neuropathic pain. "Recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). Topical lidocaine, in the formulation of a dermal patch (Lidoderm®) has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy." Lidocaine patches are indicated for neuropathic pain only after trial of tri-cyclic, anti-depressants, or anti-epileptic drugs (AEDs). It is also indicated for "localized peripheral pain." A review of medical records dating 02/14/2013 to 09/27/2013 does not show evidence of "localized peripheral pain." The requested Lidoderm patches are not medically necessary and recommendation is for denial.

**Phenergan 25mg, #60:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Pain Chapter.

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

**Decision rationale:** This patient presents with chronic lumbar spine pain, which radiates down the posterior aspect of the left lower extremity to the bottom of the foot. Treating physician is requesting Phenergan 25mg. However, there is not a single mention of nausea or vomiting in the medical file provided for review. MTUS and ACOEM guidelines do not discuss Phenergan. However, ODG guidelines states "Promethazine (Phenergan®) is a phenothiazine. It is recommended as a sedative and antiemetic in pre-operative and post-operative situations." There is no indication that this patient is in a "pre-operative or post-operative" situation; therefore, recommendation is for denial.