

<b>Case Number:</b>	CM13-0044048		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	09/08/2003
<b>Decision Date:</b>	03/06/2014	<b>UR Denial Date:</b>	10/23/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/25/2013

### 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 & Rehabilitation, and is licensed to practice in Texas. 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 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 61-year-old female who reported an injury on 08/08/2003. The mechanism of injury was not provided in the medical records. The patient's diagnoses include chronic low back pain, status post lumbar fusion, lumbar radiculopathy, and opioid induced constipation. Her medications were noted to include Duragesic 50 mcg per hour patch, Nucynta 100 mg every 6 hours as needed, Neurontin 1200 mg 3 times a day, Prozac 20 mg daily, Soma 350 mg daily as needed, and Voltaren 1% gel 4 times a day as needed.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy #18:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**Decision rationale:** According to the MTUS Chronic Pain Guidelines, physical medicine is recommended at 8 to 10 visits over 4 weeks for the treatment of unspecified radiculitis. The most recent office note provided dated 11/07/2013 indicated that the patient had completed 3 sessions of physical therapy and was participating in home exercises. The clinical information

submitted is unclear on how many physical therapy visits the patient has completed to date. Additionally, the documentation failed to provide evidence of objective functional gains made with previous physical therapy. Moreover, the request for 18 physical therapy visits exceeds the guideline's recommendation for a total of 8 to 10 visits over 4 weeks in the treatment of unspecified radiculitis. For these reasons, the requested service is not medically necessary and appropriate.

**Soma 350mg #30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol Page(s): 29.

**Decision rationale:** According to the MTUS Chronic Pain Guidelines, Soma is not recommended. It further specifies that this medication is not indicated for long-term use and has a high abuse rate due to its sedative and relaxant effects. The clinical information provided indicates the patient has been utilizing Soma since at least 11/19/2012. As the guidelines specifically state that this medication is not indicated for long-term use, the request is not medically necessary and appropriate.

**Voltaren 1% gel #5:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

**Decision rationale:** According to the MTUS Chronic Pain Guidelines, Voltaren is indicated in the treatment of osteoarthritis pain in joints that lend themselves to topical treatment. However, the use of topical Voltaren gel 1% has not been evaluated for the treatment of the spine, hip, or shoulder. As the patient's diagnoses and symptoms revolve around her lumbar spine and the use of Voltaren gel is not recommended for use in the lumbar spine, the request is not supported. As such, the request is not medically necessary and appropriate.

**Repeat right S1 transforaminal epidural steroid injection:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections Page(s): 46.

**Decision rationale:** According to the MTUS Chronic Pain Guidelines, epidural steroid injections may be recommended for patients with radiculopathy documented by physical exam or corroborated by imaging studies and/or electrodiagnostic testing. The patient's most recent physical exam findings indicated that there were, "Patchy areas of diminished pinprick sensation in the right lower leg." However, the specific dermatomes in which diminished sensation was revealed were not noted. Additionally, there were no imaging studies or electrodiagnostic testing results provided in order to correlate with her physical examination findings. Moreover, the MTUS Chronic Pain Guidelines indicate that repeat blocks should be based on continued objective documented gain and functional improvement and the documentation should note at least 50% pain relief with associated reduction of medication use for 6 to 8 weeks following previous injections. The clinical information submitted indicates that the patient had a previous right S1 transforaminal epidural steroid injection; however, documentation indicating that she reported at least 50% pain relief and was able to reduce her medications was not provided. In the absence of this documentation and for the reasons stated above, the request is not medically necessary and appropriate.