

<b>Case Number:</b>	CM14-0006977		
<b>Date Assigned:</b>	02/07/2014	<b>Date of Injury:</b>	08/22/2003
<b>Decision Date:</b>	07/24/2014	<b>UR Denial Date:</b>	01/02/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/15/2014

### 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. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. 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/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 63-year-old male who has submitted a claim for failed low back pain syndrome with continued multimodality pain, lumbar facet osteoarthritis, situational depression, and lumbar radiculopathy associated with an industrial injury date of August 22, 2003. Medical records from 2012-2014 were reviewed. The patient complained of low back pain, grade 8-9/10 in severity. The pain radiates to both legs. The pain was worsened by activity. Physical examination showed tenderness and tightness with trigger points throughout the lumbosacral spine. There is greater than 50% restriction of range of motion in all planes. Straight leg raise was positive bilaterally in the L3-L4 and S1 distribution. Patrick's test was equivocal secondary to pain. There was noted dysesthesia and hypoesthesia in bilateral anterior and posterior legs down to the ankles. Motor strength was 4/5 in the lower extremity muscle groups secondary to pain. MRI of the lumbar spine, dated March 9, 2014, revealed progression of the discogenic degenerative changes at L3-L4 especially along the right side, with severe narrowing of the right L3 neural foramen; and increase in the subarticular and foraminal disc protrusion at L2-L3, left side with moderate narrowing of the left L2 neural foramen. Treatment to date has included medications, massage therapy, chiropractic therapy, aquatic therapy, TENS unit, home exercise program, activity modification, lumbar epidural steroid injections, and lumbar spinal fusion and discectomy. The utilization review, dated January 2, 2014, denied the request for 1 bilateral L3-L4 and L5-S1 transforaminal epidural steroid injection because of lack of objective documented pain relief on past injections, and there was no diagnostic imaging to corroborate radiculopathy at L3-L4 level. The request for Percocet 10/325mg #120 was denied because weaning was already initiated and patient's objective and subjective findings have not changed considerably since that time. Valium 5mg #90 was denied because was not a candidate for continued use or deviation from the guidelines with further treatment with this medication.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **BILATERAL L3-4 AND L5-S1 TRANSFORMINAL EPIDURAL STEROID INJECTION:**

Upheld

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

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

**Decision rationale:** According to page 46 of the CA MTUS Chronic Pain Medical Treatment Guidelines, criteria for epidural steroid injections include the following: radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing; initially unresponsive to conservative treatment; and no more than two nerve root levels should be injected using transforaminal blocks. Guidelines do not support epidural injections in the absence of objective radiculopathy. In addition, repeat epidural steroid injection 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. In this case, the patient has persistent low back pain that radiates to both legs. According to the patient, previous epidural steroid injections of the lumbar spine greatly benefited him in the past. However, objective pain relief measures and evidence of functional improvement were not documented. The patient presented with decreased motor strength at 4/5 in the lower extremities, and decreased sensation in the anterior and posterior legs down to the ankles. MRI of the lumbar spine dated March 9, 2014 revealed severe narrowing of the right L3 neural foramen and narrowing of the left L2 neural foramen. The MRI result does not corroborate with the patient's non-specific physical examination findings. Furthermore, there was no evidence that patient was unresponsive to conservative treatment. The guideline criteria have not been met. Therefore, the request for bilateral L3-4 and L5-S1 transforaminal epidural steroid injection is not medically necessary.

### **PERCOCET 10/325MG, QTY: 120:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, page 78 Page(s): 78.

**Decision rationale:** As stated on page 78 of CA MTUS Chronic Pain Medical Treatment Guidelines, there are 4 A's for ongoing monitoring of opioid use: pain relief (analgesia), side effects (adverse side effects), physical and psychosocial functioning (activities of daily living) and the occurrence of any potentially aberrant drug-related behaviors. The monitoring of these

outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. In this case, patient has been taking Percocet since February 2011. The patient claims that there is improvement of his pain with medication. However, specific measures of analgesia and functional improvements such as improvements in activities of daily living were not documented. There was also no documentation of adverse effects or aberrant drug-taking behaviors. MTUS Guidelines require clear and concise documentation for ongoing management. Therefore, the request for Percocet 10/325mg # 120 is not medically necessary.

**VALIUM 5MG, #68:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

**Decision rationale:** As noted on page 24 of the CA MTUS Chronic Pain Medical Treatment Guidelines, benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks. In this case, the patient has been on Valium since February 2011 for muscle spasms. This medication is not recommended for long-term use. Functional benefits from its use were not discussed as well. The medical necessity has not been established. Therefore, the request for Valium 5MG #68 is not medically necessary.