

<b>Case Number:</b>	CM14-0108385		
<b>Date Assigned:</b>	08/01/2014	<b>Date of Injury:</b>	03/22/2004
<b>Decision Date:</b>	09/03/2014	<b>UR Denial Date:</b>	06/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/11/2014

### 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 Physical Medicine & Rehabilitation, and is licensed to practice in Illinois. 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 injured worker is a 58-year-old male who reported an injury on 03/18/2014. On 03/18/2014, the injured worker presented with neck pain and occasional headache with lower back pain and numbness to the bilateral legs. Upon examination of the lumbar spine, there was tenderness over the L4-5 and L5-S1 facets bilaterally. There was limited range of motion, positive facet loading test bilaterally. There was a positive right-sided straight leg raise and a right-sided positive LeSegue test. The neurological examination revealed dermatomal changes mostly L5-S1 on the right side. The diagnoses were lumbar radiculopathy on the right, lumbar facet arthropathy L4-5 and L5-S1, disc protrusion L2-3, L3-4, L4-5 L5-S1 and discogenic versus facetogenic cervical spine pain. The injured worker has had a prior Epidural Steroid Injection in 04/2013. Current medications included Naproxen, Gabapentin, Paxil, Cyclobenzaprine, and Percocet. The provider recommended a lumbar ESI to the right, Gabapentin, Paxil, a urine drug screen, Cyclobenzaprine and Percocet. The provider's rationale was not provided. The request for authorization form was not included in the medical documents for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lumbar epidural steroid injection under fluoroscopic guidance at L5-S1 level on the right right side:** 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(s): 46.

**Decision rationale:** The request for a Lumbar Epidural Steroid Injection under Fluoroscopic Guidance, L5-S1 level on the right side, is not medically necessary. The California MTUS Guidelines recommend ESI as an option for treatment of radicular pain. An Epidural Steroid Injection can offer short-term relief and use should be in conjunction with other rehabilitation efforts including a home exercise program. There is no information on improved function. The criteria for use of an ESI include radiculopathy must be documented by physical examination and corroborated by imaging studies, be initially unresponsive to conservative treatment, injections should be performed using fluoroscopy for guidance, and no more than 2 levels should be injected using transforaminal blocks. The criteria for use of a repeat Epidural Steroid Injection include at least a 50% pain relief associated with reduction of medication for 6 to 8 weeks. The submitted documentation notes a positive right-sided straight leg raise. There was lack of documentation of at least a 50% pain relief of pain with associated reduction of medication for 6 to 8 weeks with the prior Epidural Steroid Injection. Additionally, there is a lack of documentation of physical exam corroborated by imaging studies and/or electrodiagnostic testing that show radiculopathy. As such, the request is not medically necessary.

**Gabapentin 300mg #60 with 2 refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti- Epilepsy Drugs (AEDs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants for pain Page(s): 63.

**Decision rationale:** The request for Gabapentin 300 mg with a quantity of 60 and 2 refills is not medically necessary. The California MTUS Guidelines recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations. There are no benefits beyond NSAIDs in pain and overall improvement and efficacy appears to diminish over time. Prolonged use of some medications in this class may lead to dependence. The provider's request for Gabapentin with a quantity of 60 and 2 refills exceed the guideline recommendations of short-term treatment. Additionally, the provider's request does not indicate the frequency of the medication in the request as submitted. As such, the request is not medically necessary.

**Paxil 20mg #30 with 2 refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines SSRI's (Selective Serotonin Reuptake Receptors) Page(s): 107.

**Decision rationale:** The request for Paxil 20 mg with a quantity of 30 and 2 refills is not medically necessary. The California MTUS Guidelines does not recommend Paxil as treatment for chronic pain, but may have a role in treating secondary depression. SSRIs (Selective Serotonin Reuptake Receptors), is a class of antidepressants that inhibits Serotonin Reuptake without action of noradrenalin and are controversial based on controlled trials. As the guidelines do not recommend SSRIs, Paxil would not be indicated. There is a lack of exceptional factors provided in the documentation submitted to support approving outside the guideline recommendations. As such, the request is not medically necessary.

**Urine drug screen:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, steps to avoid misuse/addiction.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Urine Drug Screen Page(s): 43.

**Decision rationale:** The request for a Urine Drug Screen is not medically necessary. The California MTUS Guidelines recommend a urine drug screen test as an option to assess for the use or presence of illegal drugs. It may also be used in conjunction with a therapeutic trial of opioids, for ongoing management and as a screening for risk of misuse and addiction. The documentation provided did not indicate the injured worker displayed any aberrant behaviors, drug seeking behaviors, or whether the injured worker was suspected of illegal drug use. It was unclear when the last urine drug screen was performed. As such, the request is not medically necessary.

**Cyclobenzaprine 10mg #30 with 2 refills:** Upheld

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

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

**Decision rationale:** The request for Cyclobenzaprine 10 mg with a quantity of 30 and 2 refills is not medically necessary. The California MTUS Guidelines recommend Cyclobenzaprine as an option for short-term therapy. The greatest effect of the medication is in the first 4 days of treatment, suggesting that shorter courses may be better. Treatment should be brief. The request for Cyclobenzaprine 10 mg with a quantity of 30 and 2 refills exceed the guideline recommendations of short-term therapy. The provided medical records lack documentation of significant objective functional improvement with the medication. The provider's rationale was not provided within the documentation. As such, the request is no medically necessary.

**Percocet 7.5/325mg #60with 2 refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for use.

**Decision rationale:** The requested Percocet 7.5/325 mg with a quantity of 60 and 2 refills is not medically necessary. The California MTUS Guidelines recommend the use of opioids for ongoing management of chronic pain. The guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be evident. There is a lack of evidence of an objective assessment of the injured worker's pain level, functional status, evaluation of risk for aberrant drug abuse behavior, and side effects. Additionally, the provider's request did not indicate the frequency of the medication in the request as submitted. As such, the request is not medically necessary.