

<b>Case Number:</b>	CM14-0111597		
<b>Date Assigned:</b>	08/01/2014	<b>Date of Injury:</b>	04/13/2000
<b>Decision Date:</b>	09/24/2014	<b>UR Denial Date:</b>	07/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/17/2014

### 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 and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Ohio. 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 37-year-old male who reported an injury on 04/13/2000. On 05/29/2014, the injured worker presented with lower back pain and stiffness. Upon examination of the lumbar spine, there were 80 degrees of flexion and 20 degrees of extension. There was a positive right-sided straight leg raise and 4/5 weakness in the quad and tibialis anterior. There was also 5- weakness in the peroneus and toe flexors. The diagnoses were an L4-5 disc bulge, L5-S1 radicular pain and weakness, and L5 facet syndrome, right greater than left. Prior therapy included an epidural steroid injection that reduced pain by 50% for 3 months. Therapy also included the use of a gym and medications. The provider recommended a lumbar transforaminal epidural steroid injection, bilateral lumbar facet injections, and lidocaine patches. 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 transforaminal steroid injection:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIS) Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter.

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

**Decision rationale:** The request for Lumbar transforaminal steroid injection is not medically necessary. According to the California MTUS Guidelines, an epidural steroid injection may be recommended to facilitate progress in more active treatment programs when there is radiculopathy documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Additionally, documentation should show that the injured worker was initially unresponsive to conservative treatment. Injections should be performed using fluoroscopy, and no more than 2 nerve root levels should be injected using transforaminal blocks. The documentation submitted for review stated that the injured worker had completed initially recommended conservative treatment, but continued to complain of pain. His physical exam findings included a positive right-sided straight leg raise test, as well as normal motor strength and increased weakness in the quad and tibialis anterior. No sensory deficits were noted. Further clarification is needed to address the sensation deficits in the bilateral lower extremities prior to proceeding with injection, as the physical exam and diagnostic testing findings do not clearly corroborate radiculopathy. In addition, the documentation failed to show that the injured worker would be participating in an active treatment program following the requested injection. In summary, in the absence of clear corroboration of radiculopathy by physical exam findings and imaging study or electrodiagnostic test results, and documentation showing a plan for active therapy following injection, the request is not supported. Moreover, the request failed to specify the level or levels being requested. Based on the above, the request is not medically necessary.

**Bilateral lumbar facet injection:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIS) Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-300.

**Decision rationale:** The request for Bilateral lumbar facet injection is not medically necessary. The California MTUS/ACOEM Guidelines state invasive techniques such as facet joint injections are of questionable merit. Despite the fact that proof is still lacking, many pain physicians believe that diagnostic and/or therapeutic injections may have benefit for injured workers presenting in the transitional phase between acute and chronic pain. The included medical documents lack evidence of the injured worker's initial unresponsiveness to conservative treatment, which would include exercises, physical methods, and medications. The guidelines note that facet injections may aid in the transitional phase from acute to chronic pain; however, the injured worker is already in the chronic stage of her injury. The provider's request failed to specify the levels being requested in the request as submitted. As such, the request is not medically necessary.

**Lidocain patches 1 every 12 hours:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (lidocaine patch) Page(s): 56-57. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Pain Chapter, Lidoderm Patches.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (Lidocaine Patch) Page(s): 56.

**Decision rationale:** The request for Lidocain patches 1 every 12 hours is not medically necessary. The California MTUS Guidelines state lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of a first line therapy; tricyclic or SNRI antidepressants, or an AED such as Gabapentin or Lyrica. This is not a first line treatment and it is only FDA approved for postherpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than postherpetic neuralgia. The included documentation lacked evidence of the injured worker having a diagnosis congruent with the guideline recommendation for lidocaine patch. Additionally, there is a lack of evidence that the injured worker had failed a trial of an SNRI antidepressant or an AED such as Gabapentin or Lyrica. Additionally, the provider's request does not indicate the dose or quantity of the lidocaine patches in the request as submitted. As such, the request is not medically necessary.