

<b>Case Number:</b>	CM14-0152184		
<b>Date Assigned:</b>	10/01/2014	<b>Date of Injury:</b>	09/13/2013
<b>Decision Date:</b>	10/28/2014	<b>UR Denial Date:</b>	09/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/18/2014

### 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 Emergency 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:

This case involves an injured worker with a date of injury on 9/13/2013. Mechanism of injury is described as from working a pick leading to back injury. The current diagnosis is lumbar disc displacement, spondylosis lumbosacral and sciatica. Medical reports reviewed. The last report available was until 9/19/14, which the patient complained of low back pain with severe pain that radiates to the right leg. Also notes weakness and pain to right leg. Pain is 7-8/10. Objective exam reveals limited range of motion (ROM) of lumbar spine especially with flexion and extension. Sensation decreased at right L5 and right S1 dermatomes. Straight leg raise positive on right side. Spasms and guarding noted in lumbar spine and normal strength was noted. Noted was that the patient required increased dose of Norco for pain control on 8/22/14. Noted was constipation and heart burn sensation with medications. A Letter of appeal of UR denial dated 9/19/14 was reviewed. It states that patient has undergone physical therapy and other conservative therapy with minimal improvement. Also is not considered a surgical candidate but has yet to be assessed by a spine surgeon. Plan is to decrease pain to return patient to work. This letter only dealt with lumbar epidural steroid injection (LESI) denial and not with medications. The EMG of bilateral lower extremities (8/19/14) revealed right L5 radiculopathy and bilateral S1 radiculopathy. The MRI of lumbar spine (8/1/14) revealed disc and facet arthropathy with left neural foraminal stenosis with contact on left L4 nerve root, L5-S1 right dorsolateral osteophyte with displacement of R S1 root. Current medications include Neurontin, Soma, Sertraline, Vicodin, Meloxicam and Ranitidine. The patient has reportedly undergone physical therapy (unknown number), chiropractic and acupuncture with little improvement. Independent Medical Review is for Cyclobenzaprine 10mg #90 with 3refills, Docusate sodium 250mg #60 with 3refills, Gabapentin 100mg #180 with 3refills, Meloxicam #60 with 3refills, Ranitidine HCL 150mg #60 with 3refills, Lumbar epidural Steroid injection(LESI) Right side at L4-5 and

L5-S1, "decision for 2each additional levels", lumbar epidurogram, fluoroscopic guidance and IV sedation. Prior UR on 9/11/14 recommended non-certification with modification of Decusate, Meloxicam and Ranitidine to 1 refill each.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **1 prescription of Cyclobenzaprine 10mg #90 with 3 refills: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine(Flexeril) Page(s): 41-42.

**Decision rationale:** Cyclobenzaprine or Flexeril is a muscle relaxant. As per MTUS Chronic pain guidelines, it is recommended for muscle spasms. It is recommended in short term use and has mixed evidence for chronic use with no specific recommendation for chronic use. There is no documentation by the provider about objective improvement in muscle spasms or proper monitoring of side effects. The number of tablet is does not meet MTUS recommendation for short term use. Therefore, this request for Cyclobenzaprine is not medically necessary.

#### **1 prescription of Docusate Sodium 250mg #60 with 3 refills: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation McKay SL, et al. Management of Constipation. Iowa City (IA): University of Iowa Gerontological Nursing Interventions Research Center, Research Translation and Dissemination Core; 2009 Oct 51p

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 77.

**Decision rationale:** As per MTUS Chronic pain and ACOEM Guidelines, constipation treatment or prophylaxis only relates to patients undergoing opioid therapy. The patient is on opioids with documented constipation; therefore, this request is medically necessary.

#### **1 prescription of Gabapentin 100mg #180 with 3 refills: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy Drugs (AEDS).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs(AEDs) Page(s): 18-19.

**Decision rationale:** Gabapentin (Neurontin) is an anti-epileptic drug with efficacy in neuropathic pain. The patient has documentation of neuropathic pains specifically radiculopathy

confirmed by EMG. However, the number of tablets prescribed is excessive and does not meet proper MTUS guideline for proper monitoring of improvement and side effects. The prescription of Gabapentin with #180 tabs with 3 refills is not medically necessary.

**1 prescription of Meloxicam 7.5mg #60 with 3 refills: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs(Non-steroidal anti-inflammatory drugs) Page(s): 67.

**Decision rationale:** Meloxicam is a non-steroidal anti-inflammatory drug (NSAID). As per MTUS Chronic pain guidelines, NSAIDs are useful of osteoarthritis related pain but less so in other types of pains. Due to side effects and risks of adverse reactions, MTUS recommends as low dose and short course as possible. There is no documentation by the provider of improvement in pain despite being prescribed chronically and there are signs of dyspepsia due to NSAID use. Therefore, this request is not medically necessary.

**1 prescription of Ranitidine HCL 150mg #60 with 3 refills: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation University of Michigan Health System. Gastroesophageal Reflux Disease (GERD). Ann Arbor (MI): University of Michigan Health System; 2012 May. 12p

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms and cardiovascular risks Page(s): 68-69.

**Decision rationale:** Ranitidine is an H2-blocker used for dyspepsia from NSAID use or gastritis/peptic ulcer disease. As per MTUS guidelines, H2blockers or proton pump inhibitors (PPI) may be used in patients with high risk for gastric bleeds or problems or signs of dyspepsia. The documentation concerning the patient does not meet any high risk criteria to warrant PPIs. The patient has reported heart burn from medication use, however NSAID is not indicated in this patient (see review of Meloxicam); therefore, an H2 blocker is not indicated as well. As such, this request is not medically necessary.

**1 right lumbar epidural steroid injection (LESI) at L4-5 and L5-S1: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection (ESI).

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

**Decision rationale:** As per MTUS Chronic Pain Guidelines, Epidural Steroid Injections (ESI) may be useful in radicular pain and may recommend if it meets criteria. The basic criteria are: 1) Goal of ESI: ESI has no long term benefit. It can decrease pain in short term to allow for increasingly active therapy or to avoid surgery. The documentation states that the ESI was to decrease worsening pain. Plan was to decrease with plan to return patient back to work and decrease medication use. 2) Unresponsive to conservative treatment. The patient has attempted physical therapy, acupuncture and other treatments with no improvement. As clearly stated in MTUS Chronic pain guidelines, patient has to meet all basic criteria before ESI can be recommended. As such, this patient meets the criteria for an LESI based on the provided documentation. Therefore, this request is medically necessary.

**2 each additional levels:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection (ESI).

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

**Decision rationale:** As per MTUS Chronic Pain Guidelines, Epidural Steroid Injections (ESI) may be useful in radicular pain and may recommend if it meets criteria. The basic criteria are: 1) Goal of ESI: ESI has no long term benefit. It can decrease pain in short term to allow for increasingly active therapy or to avoid surgery. The documentation states that the ESI was to decrease worsening pain. Plan was to decrease with plan to return patient back to work and decrease medication use. 2) Unresponsive to conservative treatment. The patient has attempted physical therapy, acupuncture and other treatments with no improvement. As clearly stated in MTUS Chronic pain guidelines, patient has to meet all basic criteria before ESI can be recommended. As such, this patient meets the criteria for an LESI based on the provided documentation. As per MTUS Chronic pain guidelines, not more than 2 levels are recommended. 2 levels are medically necessary. Therefore, this request is medically necessary.

**1 lumbar epidurogram:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection (ESI).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) <Low back complaints>, <Myelography>

**Decision rationale:** MTUS Chronic pain or ACOEM does not adequately deal with this topic. Official Disability Guidelines (ODG) recommended myelography only for identification of cerebrospinal fluid leak, surgical/radiation planning, evaluation of spinal or basal cistern disease or inability to get an MRI myelography. Patient does not meet any of these indications; therefore, this request is not medically necessary.

**Fluoroscopic guidance x 1: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection (ESI).

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

**Decision rationale:** See LESI review and approval above for details. LESI is medically necessary. As per MTUS Chronic pain guidelines, fluoroscopy is recommended when performing LESI; therefore, this request is medically necessary.

**1 IV sedation: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation <American Society of Anesthesiologists Task Force on Chronic Pain Management, American Society of Regional Anesthesia and Pain Medicine. Practice guidelines for chronic pain management: an updated report by the American Society of Anesthesiologists Task Force on Chronic Pain Management and the American Society of Regional Anesthesia and Pain Medicine. Anesthesiology. 2010 Apr;112(4):810-33.>

**Decision rationale:** MTUS Chronic pain, ACOEM and Official Disability Guidelines do not adequately address this topic. American Society of Anesthesiology guidelines do not recommend IV sedation as a default practice during diagnostic or therapeutic nerve blocks. The provider has no provided any rationale as to why sedation is needed such as severe patient anxiety. Therefore, this request is not medically necessary.