

<b>Case Number:</b>	CM14-0037855		
<b>Date Assigned:</b>	06/25/2014	<b>Date of Injury:</b>	09/17/2010
<b>Decision Date:</b>	09/09/2014	<b>UR Denial Date:</b>	02/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/31/2014

### 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 Internal Medicine, has a subspecialty in Hospice and Palliative Medicine and is licensed to practice in Pennsylvania. 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 51-year-old woman with a date of injury of 09/17/2010. A QME report by the treating physician dated 08/13/2013 identified the mechanism of injury as lifting and moving heavy boxes resulting in lower back and left shoulder pain. This QME report and office visit notes by the treating physician dated 01/10/2014 and 02/06/2014 indicated the worker was experiencing painful lower back spasms, numbness and tingling in the left thigh and lower back, fatigue, head pains at the back of the head, and depression with anxiety. The other treating physician QME report recorded ibuprofen as the only medication at that time. The treating physician note dated 02/06/2014 recorded an opioid medication with acetaminophen three times a day and a muscle relaxant medication before bed. Documented examinations consistently described tenderness in the lower back muscles without significant spasm appreciated. The treating physician's note dated 02/06/2014 also described decreased pelvic movement, mild weakness in the left foot strength, and decreased feeling in the left thigh and along the L4 nerve. The submitted and reviewed documentation concluded the worker was suffering from on-going lower back pain with spasm, left L4 radiculitis, and a history of cocaine and alcohol addiction in the near past. Treatment recommendations included medication injected near the lower spine, continued opioid medication three times a day, increased gabapentin 600 mg two tablets before bed for nerve pain, and continued home exercise program.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left L4-5 transforaminal lumbar epidural injection: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines; Epidural Steroid Injections; Criterial for use Epidural Steroid Injections.

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

**Decision rationale:** The MTUS Guidelines recommend the use of ESIs for short-term treatment of radicular pain. The goal is to decrease pain and improve joint motion, resulting in improved progress in an active treatment program. The radiculopathy must be documented by examination and by imaging studies and/or electrodiagnostic testing. Some additional required documentation includes failed conservative treatment, functional improvement and at least a 50% reduction in pain after treatment with an initial injection, and a reduction in pain medication use lasting at least six to eight weeks. The submitted and reviewed documentation did not discuss prior treatment in any detail and did not indicate improved function or record decreased pain following prior injections. In the absence of such evidence, the current request for a left L4-5 transforaminal lumbar epidural injection is not medically necessary.

**Norco/Hydrocodone 10mg:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines; Therapeutic trial of opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Weaning of Medications Page(s): 74-95, 124.

**Decision rationale:** Norco is a combination of the opioid medication Hydrocodone and acetaminophen. The MTUS Guidelines stress the lowest possible dose of opioid medications should be prescribed to improve pain and function, and monitoring of outcomes over time should affect treatment decisions. The documentation of pain assessments should include the current pain intensity, the lowest intensity of pain since the last assessment, the average pain intensity, pain intensity after taking the opioid medication, the amount of time it takes to achieve pain relief after taking the opioid medication, the length of time the pain relief lasts, use and of drug screening with issues of abuse or addiction. Acceptable results include improved function, decreased pain, and/or improved quality of life. The MTUS Guidelines recommend opioids be continued when the worker has returned to work and if the worker has improved function and pain control. When these criteria are not met, an individualized taper of medication is recommended to avoid withdrawal symptoms. The submitted and reviewed documentation indicated the worker's back pain had increased. However, there was no detailed discussion of any of the other recommended elements of a pain assessment. Further, while a QME report by the other treating physician dated 08/13/2013 indicated the worker had a history of cocaine and alcohol addiction in the near past, the pain assessments reviewed did not record any assessment of risk or drug screening. A faster taper is warranted given the seriousness of the risks of continued use of the medication with no documented significant benefit, the current use on an as-

needed basis, and a short-acting and lower potency medication. For these reasons, the current request for Norco (hydrocodone with acetaminophen) is not medically necessary.

**Neurontin/Gabapentin 800mg:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Treatment Guidelines; Anti-epilepsy drugs (AED).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy Drugs (AEDs) Page(s): 16-19.

**Decision rationale:** Gabapentin (Neurontin) is medication in the anti-epilepsy drug class. The MTUS Guidelines recommend its use for the treatment of neuropathic pain for its efficacy and favorable side effect profile. The documentation should include the change in pain and function at each visit, especially during the dose adjustment phase. The submitted and reviewed documentation concluded the worker was suffering from lumbar radiculitis. There was no discussion of when this medication was started, baseline pain and function at that time, improvement of pain and/or function with dose increases, or side effects. In the absence of such evidence, the current request for Neurontin (gabapentin) 600 mg is not medically necessary.