

<b>Case Number:</b>	CM14-0095218		
<b>Date Assigned:</b>	07/25/2014	<b>Date of Injury:</b>	06/04/2012
<b>Decision Date:</b>	09/29/2014	<b>UR Denial Date:</b>	06/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/23/2014

### 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 and is licensed to practice in Nevada. 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 records, presented for review, indicate that this 40-year-old individual was reportedly injured on June 4, 2012. The mechanism of injury was not listed in these records reviewed. The most recent progress note, dated July 11, 2014, indicated that there were ongoing complaints of low back pain with radiation to the bilateral lower extremities. The pain level was described as 6/10 to 8/10. The physical examination demonstrated a 5'10", 110 pound individual who was normotensive (127/82). The injured employee was noted to be well-nourished, well hydrated and in no acute distress. A normal gait pattern was reported. There was bilateral lumbar muscle spasm noted and diminished strength in the right lower extremity. Sensory examination was also decreased in the right lower extremity. A loss of deep tendon reflexes in the left lower extremity was reported. Diagnostic imaging studies were not presented for review. Previous treatment included microdiscectomy, physical therapy, multiple medications and pain management interventions. A request had been made for transforaminal epidural steroid injections and medication and was not certified in the pre-authorization process on June 4, 2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Outpatient lumbar transforaminal epidural steroid injection (ESI) bilaterally at the L4-L5:**  
Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46 of 127..

**Decision rationale:** As outlined in the Chronic Pain Medical Treatment Guidelines, there is a support for a epidural steroid injection when radiculopathy is documented and corroborated by imaging, MRI and/or diagnostic studies. The medical records, presented for review, do not demonstrate diagnostic evidence of a verifiable radiculopathy. Furthermore, the MRI is somewhat equivocal and there is a history of a previous microdiscectomy. Thus, when noting the findings on physical examination and with the above said parameters, there is insufficient clinical evidence presented to support the medical necessity of such intervention. Therefore, the request for an outpatient lumbar transforaminal epidural steroid injection bilaterally at the L4-L5 is not medically necessary or appropriate.

**Percocet 10/325 mg, 120 count:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-78, 88, 91 of 127..

**Decision rationale:** As outlined in the Chronic Pain Medical Treatment Guidelines, there is a clinical indication for a short acting opioids indicated for management of moderate to severe breakthrough pain. However, this management protocol outlined is for a continuous use of this medication. Furthermore, there is no objective data presented, establishing that there has been an increase in function or a decrease in pain symptomatology. Therefore, it is not clear that this medication is reaching its intended goal. Given this lack of efficacy, there is no clear clinical indication presented for the continued use of this preparation. Therefore, the request for Percocet 10/325 mg, 120 count, is not medically necessary or appropriate.