

<b>Case Number:</b>	CM14-0175148		
<b>Date Assigned:</b>	10/28/2014	<b>Date of Injury:</b>	11/13/2004
<b>Decision Date:</b>	01/08/2015	<b>UR Denial Date:</b>	10/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/22/2014

### 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 Anesthesiology, has a subspecialty in Pain Management 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:

According to the records made available for review, this is a 57-year-old male with an 11/13/04 date of injury, and left total knee replacement on 4/30/10. At the time (9/2/14) of request for authorization for Voltaren 1%, one tube; Norco 10/325 mg, 180 count; Physical therapy for the neck and lumbar regions, twice weekly for six weeks; and Bilateral Lumbar Epidural Steroid Injection (ESI) at L3-S1, there is documentation of subjective (mid back, lower back, upper back, bilateral shoulder, and knee pain) and objective (painful lumbar range of motion, positive bilateral straight leg raising test, positive spasm in the thoracic lumbar region, positive left shoulder impingement sign, decreased cervical range of motion, diminished sensation at the C7 distributions, left knee swelling, +2 anterior cruciate ligament laxity, and right knee tenderness over the medial and lateral joint with positive patellofemoral crepitation) findings, imaging findings (reported MRI of the lumbar spine (12/20/13) revealed multilevel lumbar degenerative disc disease from L2-S1 with neuroforaminal narrowing at multiple levels, disc desiccation noted at L2-3 to L5-S1 levels, and grade I Anterolisthesis of L4 over L5 noted without evidence of pars fracture; report not available for review), current diagnoses (bilateral shoulder impingement; cervical, thoracic, and lumbar strain; lumbar radiculitis; cervical radiculitis; and lumbar spondylolisthesis), and treatment to date (medications (including ongoing treatment with Norco and Voltaren gel)). Regarding Voltaren 1%, one tube, there is no documentation of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist); short-term use (4-12 weeks); failure of an oral NSAID or contraindications to oral NSAIDs; and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Voltaren gel use to date. Regarding Norco 10/325 mg, 180 count, there is no documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being

prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects; and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Norco use to date. Regarding Physical therapy for the neck and lumbar regions, twice weekly for six weeks, it cannot be determined if this is a request for initial or additional physical therapy. Regarding Bilateral lumbar epidural steroid injection (ESI) at L3-S1, there is no specific (to a nerve root distribution) documentation of subjective (pain, numbness, and tingling) and objective (sensory changes, motor changes, or reflex changes) radicular findings in each of the requested nerve root distributions; an imaging report; that no more than two nerve root levels are to be injected in one session; of failure of additional conservative treatment (physical modalities); and glaring contraindications to surgery should an ESI fail to provide durable results.

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

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

**Voltaren 1%, one tube:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Voltaren Gel

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Non-steroidal anti-inflammatory agents (NSAIDs) Page(s): 111-112. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Diclofenac sodium Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist) and short-term use (4-12 weeks), as criteria necessary to support the medical necessity of Voltaren Gel. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies documentation of failure of an oral NSAID or contraindications to oral NSAIDs, as criteria necessary to support the medical necessity of Voltaren Gel. Within the medical information available for review, there is documentation of diagnoses of bilateral shoulder impingement; cervical, thoracic, and lumbar strain; lumbar radiculitis; cervical radiculitis; and lumbar spondylolisthesis. However, despite documentation of knee pain, there is no documentation of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist) and short-term use (4-12 weeks). In addition, there is no documentation of failure of an oral NSAID or contraindications to oral NSAIDs. Furthermore, given documentation of ongoing treatment with Voltaren gel, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Voltaren gel use to date. Therefore, based on guidelines and a review of the evidence, the request for Voltaren 1%, one tube is not medically necessary.

**Norco 10/325 mg, 180 count:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-80. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines necessitate documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects, as criteria necessary to support the medical necessity of opioids. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of bilateral shoulder impingement; cervical, thoracic, and lumbar strain; lumbar radiculitis; cervical radiculitis; and lumbar spondylolisthesis. However, there is no documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In addition, given documentation of ongoing treatment with Norco and despite documentation that Norco helps alleviate pain, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Norco use to date. Therefore, based on guidelines and a review of the evidence, the request for Norco 10/325 mg, 180 count for the lumbar spine is not medically necessary.

**Physical Therapy for the neck and lumbar regions, twice weekly for six weeks:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back AND Neck & Upper back, Physical therapy (PT)

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines support a brief course of physical medicine for patients with chronic pain not to exceed 10 visits over 4-8 weeks with allowance for fading of treatment frequency, with transition to an active self-directed program of independent home physical medicine/therapeutic exercise. ODG recommends a limited course of physical therapy for patients with a diagnosis of intervertebral disc disorders without myelopathy and sprains and strains of neck not to exceed 10 visits over 8 weeks. ODG also notes patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical

therapy) and when treatment requests exceeds guideline recommendations, the physician must provide a statement of exceptional factors to justify going outside of guideline parameters. Within the medical information available for review, there is documentation of diagnoses of bilateral shoulder impingement; cervical, thoracic, and lumbar strain; lumbar radiculitis; cervical radiculitis; and lumbar spondylolisthesis. In addition, given documentation of subjective (mid back, lower back, and upper back pain) and objective (painful lumbar range of motion, positive bilateral straight leg raising test, positive spasm in the thoracic lumbar region, decreased cervical range of motion, and diminished sensation at the C7 distributions) findings, there is documentation of functional deficits and functional goals. However, given documentation of an 11/13/04 date of injury where there would have been an opportunity to have had previous physical therapy, it is not clear if this is a request for initial or additional (where physical therapy provided to date may have already exceeded guidelines regarding a time-limited plan and there is the necessity of documenting functional improvement) physical therapy treatment. Therefore, based on guidelines and a review of the evidence, the request for Physical therapy for the neck and lumbar regions, twice weekly for six weeks is not medically necessary.

### **Bilateral Lumbar Epidural Steroid Injection (ESI) at L3-S1: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Epidural Steroid Injections (ESIs)

**Decision rationale:** MTUS reference to ACOEM guidelines identifies documentation of objective radiculopathy in an effort to avoid surgery as criteria necessary to support the medical necessity of epidural steroid injections. ODG identifies documentation of subjective (pain, numbness, or tingling in a correlating nerve root distribution) and objective (sensory changes, motor changes, or reflex changes (if reflex relevant to the associated level) in a correlating nerve root distribution) radicular findings in each of the requested nerve root distributions, imaging (MRI, CT, Myelography, or CT Myelography & X-ray) findings (nerve root compression OR moderate or greater central canal stenosis, lateral recess stenosis, or neural foraminal stenosis) at each of the requested levels, failure of conservative treatment (activity modification, medications, and physical modalities), and no more than two nerve root levels injected one session; as additional criteria necessary to support the medical necessity of lumbar epidural steroid injection. Within the medical information available for review, there is documentation of diagnoses of bilateral shoulder impingement; cervical, thoracic, and lumbar strain; lumbar radiculitis; cervical radiculitis; and lumbar spondylolisthesis. However, given nonspecific documentation of subjective (low back pain) and objective (painful lumbar range of motion, positive bilateral straight leg raising test, positive spasm in the thoracic lumbar region) findings, there is no specific (to a nerve root distribution) documentation of subjective (pain, numbness, and tingling) and objective (sensory changes, motor changes, or reflex changes) radicular findings in each of the requested nerve root distributions. In addition, despite documentation of medical report's reported imaging findings (MRI of the lumbar spine identifying multilevel

lumbar degenerative disc disease from L2-S1 with neuroforaminal narrowing at multiple levels), there is no documentation of an imaging report. Furthermore, given documentation of a request for Bilateral lumbar epidural steroid injection (ESI) at L3-S1, there is no documentation that no more than two nerve root levels are to be injected in one session. Moreover, despite documentation of conservative treatment (medications), and given documentation of an associated request for Physical therapy, there is no documentation of failure of additional conservative treatment (physical modalities). Lastly, there is no documentation of glaring contraindications to surgery should an ESI fail to provide durable results. Therefore, based on guidelines and a review of the evidence, the request for Bilateral Lumbar Epidural Steroid Injection (ESI) at L3-S1 is not medically necessary.