

<b>Case Number:</b>	CM14-0188683		
<b>Date Assigned:</b>	11/19/2014	<b>Date of Injury:</b>	01/31/2012
<b>Decision Date:</b>	01/07/2015	<b>UR Denial Date:</b>	10/29/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/12/2014

### 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 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 is a case of a 47 year old male with a date of injury of 1/31/2012. The injury is due to cumulative trauma. In an office visit note by [REDACTED] dated 10/9/2014, the patient was complaining of low back pain, right radicular pain, and right hip pain (secondary to hip replacement surgery). The patient returns for a follow up and had an MRI done 7/2/2014 which showed degenerative disc disease at L5-S1 with right foraminal stenosis as well as degenerative disc disease at L4-L5 without stenosis and very slight degeneration at L3-L4. It was recommended by [REDACTED] that he have transforaminal epidural steroid injection at L5-S1 which resulted in 80% relief of his back and right radicular pain for about a week, and then the pain slowly returned. He also recommended physical therapy and possible trigger point injections. The patient does not have trigger points on evaluation. The patient had significant improvement in pain with a single epidural steroid injection; improvements in function and decreased use of medication that he already takes infrequently. It was recommended that he repeat the epidural steroid injection followed by physical therapy. The patient reports no adverse effects of using Hydromorphone, and exhibits no aberrant behavior. His pain levels are 4/10 with medication and 6/10 without. It is also reported that many of his ADL's (activities of daily living) are better tolerated with medication. On physical examination, he has an antalgic gait and pain and difficulty with transfers from sitting to standing. Deep tendon reflexes are symmetrical. He has decreased range of motion with flexion and extension of the lumbar spine. He exhibits paraspinal muscle tenderness without spasm and positive straight leg lift on the right at about 45 degrees with probable neural tension signs. He is diagnosed with joint pain-ankle, joint pain-pelvis, and lumbago. It was then requested to get a repeat epidural steroid injection transforaminal right L5-S1, physical therapy 6 visits, and refill of Celebrex and Hydromorphone.

The patients past medical history are significant for hypothyroidism, arrhythmia, and obstructive sleep apnea.

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

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

**Celebrex #30 , 1 refill:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory Page(s): 67,78,98-99,45.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Non-steroidal anti-inflammatory Page(s): 22, 67-68.

**Decision rationale:** Based on MTUS guidelines, anti-inflammatories are the traditional first line of treatment, to reduce pain so activity and functional restoration can resume, but long-term use may not be warranted. COX-2 inhibitors (e.g., Celebrex) may be considered if the patient has a risk of GI complications, but not for the majority of patients. Generic NSAIDs and COX-2 inhibitors have similar efficacy and risks when used for less than 3 months, but a 10-to-1 difference in cost. Rate of overall GI bleeding is 3% with COX-2's versus 4.5% with ibuprofen. NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain from osteoarthritis. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence to recommend one drug in this class over another based on efficacy. In particular, there appears to be no difference between NSAIDs and COX-2 inhibitors in terms of pain relief. The main concern of selection is based on adverse effects. COX-2 inhibitors have fewer GI side effects at the risk of increased cardiovascular side effects, although the FDA has concluded that long-term clinical trials are best interpreted to suggest that cardiovascular risk occurs with all NSAIDs and is a class effect. There is no evidence of long-term effectiveness for pain or function. Based on MTUS guidelines, patients who are at risk for gastrointestinal events include: patients > 65 years old, patients with a history of peptic ulcer, gastrointestinal bleeding or perforation, patients with concurrent use of aspirin, corticosteroids, and /or an anticoagulant, or high dose/multiple NSAID use. In patients with no risk factors and no cardiovascular disease, a non-selective NSAID is OK, such as naproxen. In patients with intermediate risk factors for gastrointestinal events and no cardiovascular disease, a non-selective NSAID with either a proton pump inhibitor (such as omeprazole DR), or misoprostol, or a Cox-2 selective agent would be appropriate. Long term use (> 1 year) of proton pump inhibitors has been shown to increase risk of hip fracture. In patients at high risk for gastrointestinal events with no cardiovascular disease, it is recommended to use a Cox-2 selective agent plus a proton pump inhibitor. In this case, the patient is 47 years old and likely low risk for gastrointestinal events. There was no mention of previous peptic ulcer disease or gastrointestinal bleeding that would make him a higher risk candidate for which a COX-2 selective agent would be appropriate. Also, in general NSAID use should be short-term and this patient has been on Celebrex for at least several months which is longer than

recommended. Therefore, based on MTUS guidelines and the evidence in this case, the request for Celebrex #30 with one refill is not

**Hydromorphone 4mg #30:**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 72-79.

**Decision rationale:** Based on MTUS guidelines, short-acting opioids are seen as an effective method in controlling pain. They are often used for intermittent or breakthrough pain. These agents are often combined with other analgesics such as acetaminophen and aspirin. These adjunct agents may limit the upper range of dosing of short-acting agents due to their adverse effects. The duration of action is generally 3-4 hours. When considering opioids for on-going management of chronic pain, adequate review and documentation of pain relief, functional status, appropriate medication use, and side effects should be documented. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long the pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Consideration of a consultation with a multidisciplinary pain clinic is recommended if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. Some of the reasons for discontinuation of opioids include if there is no overall improvement in function, unless there are extenuating circumstances, if there is continuing pain with evidence of intolerable adverse effects, if there is decrease of functioning, or resolution of pain. In this case, the patient has been on Hydromorphone for at least several months which exceeds the recommended duration for treatment especially if there has been no overall improvement. He has not had any side effects or aberrant behavior documented. He is tolerating the medication well and it seems to reduce his pain to help improve his functionality with ADL's. It is however not well documented of how long he gets relief with the pain medication, what his average level of pain is and there is no documentation of a urine toxicology screen to verify appropriate use of the medication. Therefore, based on MTUS guidelines and the evidence in this case, the request for Hydromorphone 4 mg #30 is not medically necessary.

**Physical therapy x 6: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines -Low back , Physical Therapy

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy Page(s): 98-99.

**Decision rationale:** Based on MTUS guidelines, passive physical therapy can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. The physical medicine guidelines allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Specifically, for myalgia and myositis physical therapy is recommended for 9-10 visits over 8 weeks. 8-10 visits is recommended over 4 weeks for Neuralgia, neuritis, and radiculitis unspecified. For reflex sympathetic dystrophy, 24 visits of physical therapy over 16 weeks is recommended. The patient has a date of injury of 1/31/2012 and has suffered from chronic pain throughout this period. Passive physical therapy is for short term relief during the early phases of pain treatment. This patient is now suffering from chronic pain and physical therapy at this time is not indicated. Therefore, based on MTUS guidelines and the evidence in this case, the request for Physical Therapy x 6 is not medically necessary.

### **Epidural Steroid Injection to the right L5-S1: Upheld**

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

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

**Decision rationale:** Based on MTUS guidelines, the purpose of epidural steroid injections (ESIs) is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. Criteria for use of ESIs include: 1) Radiculopathy must be documented on physical examination and corroborated by imaging studies and/or electro diagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). 3) Injections should be performed using fluoroscopy for guidance. 4) If used for diagnostic purposes, a maximum of 2 injections should be performed. Diagnostic blocks should be at an interval of at least one to two weeks between injections. 5) No more than two nerve root levels should be injected using transformational blocks. 6) No more than one interlaminar level should be injected at one session. 7) In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. 8) Current research does not support a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 epidural steroid injections. In this case, the patient experienced 80% improvement after his prior ESI, but the relief lasted only for one week. His pain then returned and he again required the use of his pain medication as before. Therefore, based on MTUS guidelines and the evidence in this case, the request for Epidural Steroid Injection to right L5-S1 is not medically necessary.