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| <b>Case Number:</b>   | CM14-0204090 |                              |            |
| <b>Date Assigned:</b> | 12/16/2014   | <b>Date of Injury:</b>       | 11/29/2011 |
| <b>Decision Date:</b> | 02/09/2015   | <b>UR Denial Date:</b>       | 11/10/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 12/05/2014 |

### 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 Rehab, has a subspecialty in Pain 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 male patient with a date of injury of November 29, 2011. A utilization review determination dated November 10, 2014 recommends non-certification of an MRI of the lumbar spine, diagnostic ultrasound of bilateral SI joints with possible injections, cryotherapy/neuromodulation of infrapatellar saphenous and anterior cutaneous nerves of bilateral knees, urine drug screen, Butrans 100 g/hour #4 with modification to #2 with no refills for weaning purposes, Neurontin 300 mg #90 modified to #45 with no refills for weaning purposes, and Zanaflex 2 mg #90 modified to #45 with no refills for weaning purposes. A progress note dated October 20, 2014 identifies subjective complaints of low back pain and right knee pain. The patient reports a pain level of 5/10. The physical examination reveals moderate generalized tenderness of the lumbar area, marked tenderness of bilateral SI joints, generalized moderate anterior left knee tenderness, severe anterior medial joint line tenderness of the right knee, severe medial for moral condyle tenderness of the right knee, positive FABER test bilaterally, and deep tendon reflexes are normal and symmetrical. The diagnoses include chronic pain, rule out sacroilitis, bilateral knee chondromalacia, osteoarthritis of bilateral knees, and shoulder pain. The treatment plan recommends an MRI of the lumbar spine, a urine drug screen, refill of Butrans, refill of Neurontin, refill of Zanaflex, request for diagnostic ultrasound of bilateral SI joints with possible injections, and request for cryotherapy/neuromodulation infra-patellar saphenous and anterior femoral cutaneous nerves bilateral knees. There is documentation that the patient has failed trials of PT and chiropractic for his back pain. An operative report dated October 9, 2014 identifies that the patient underwent a left in the diagnostic arthroscopy, synovectomy, partial medial meniscectomy, and chondroplasty of the medial for moral condyle and patella.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **MRI of the lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, MRIs (magnetic resonance imaging).

**Decision rationale:** Regarding the request for a lumbar spine MRI, Occupational Medicine Practice Guidelines state that unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. ODG states that MRIs are recommended for uncomplicated low back pain with radiculopathy after at least one month of conservative therapy. Within the documentation available for review, there is no identification of any objective findings that identify specific nerve compromise on the neurologic exam. Additionally, there is no statement indicating what medical decision-making will be based upon the outcome of the currently requested MRI. In the absence of clarity regarding those issues, the currently requested lumbar MRI is not medically necessary.

### **Diagnostic U/S-BIL SI joints with possible injections:** Upheld

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

**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) Hip & Pelvis, Ultrasound (Sonography); Sacroiliac Blocks.

**Decision rationale:** Regarding the request for diagnostic U/S bilateral SI joints with possible injections, California MTUS does not address this issue. ODG states the indications for diagnostic ultrasound include scar tissue, adhesions, collagen fiber and muscle spasm, and the need to extend muscle tissue or accelerate the soft tissue healing. Regarding the request for sacroiliac joint injections, guidelines recommend sacroiliac blocks as an option if the patient has failed at least 4 to 6 weeks of aggressive conservative therapy. The criteria include: history and physical examination should suggest a diagnosis with at least three positive exam findings and diagnostic evaluation must first address any other possible pain generators. Within the documentation available for review, there is no indication that there is scar tissue, adhesions, collagen fiber and muscle spasm, or the need to extend muscle tissue or accelerate the soft tissue healing. Furthermore, there is no indication of at least three positive examination findings suggesting a diagnosis of sacroiliac joint dysfunction and failure of conservative treatment

directed towards the sacroiliac joint for at least 4-6 weeks. Additionally, it is unclear whether all other possible pain generators have been addressed. In the absence of such documentation, the currently requested diagnostic U/S bilateral SI joints with possible injections are not medically necessary.

**Cryotherapy/Neuromodulation-infrapatellar saphenous and anterior cutaneous nerves-bilateral knees:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee Chapter, Continuous-flow cryotherapy,

**Decision rationale:** Regarding the request for cryotherapy/neuromodulation infrapatellar saphenous and anterior cutaneous nerves-bilateral knees, California MTUS does not address the issue. ODG supports the use of continuous-flow cryotherapy for up to 7 days after knee surgery. Within the documentation available for review, the patient underwent an arthroscopy and meniscectomy of the left knee over 10 days prior to the request. In light of the above issues, the currently requested cryotherapy/neuromodulation infrapatellar saphenous and anterior cutaneous nerves-bilateral knees are not medically necessary.

**Urine drug screen:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 76-79, 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chronic Pain Chapter Urine Drug Testing.

**Decision rationale:** Regarding the request for a urine drug screen, CA MTUS Chronic Pain Medical Treatment Guidelines state the drug testing is recommended as an option. Guidelines go on to recommend monitoring for the occurrence of any potentially aberrant (or nonadherent) drug related behaviors. ODG recommends urine drug testing on a yearly basis for low risk patients, 2-3 times a year for moderate risk patients, and possibly once per month for high risk patients. Within the documentation available for review, there is no documentation of the date and results of prior testing, and current risk stratification to identify the medical necessity of drug screening at the proposed frequency. Additionally, there is no documentation that the physician is concerned about the patient misusing or abusing any controlled substances. In light of the above issues, the currently requested urine drug screen is not medically necessary.

**Butrans 100mcg/hr #4:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 MTUS (Effective July 18, 2009) Page(s): 44, 47, 75-79, 120.

**Decision rationale:** Regarding the request for Butrans 100mcg/hr #4, California Pain Medical Treatment Guidelines state that Butrans is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is no indication that the medication is improving the patient's function or pain (in terms of specific examples of functional improvement and percent reduction in pain or reduced NRS), and no discussion regarding aberrant use. In light of the above issues, the currently requested Butrans 100mcg/hr #4 is not medically necessary.

**Neurontin 300mg #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-21.

**Decision rationale:** Regarding request for Neurontin 300mg #90, Chronic Pain Medical Treatment Guidelines state that antiepilepsy drugs are recommended for neuropathic pain. They go on to state that a good outcome is defined as 50% reduction in pain and a moderate response is defined as 30% reduction in pain. Guidelines go on to state that after initiation of treatment, there should be documentation of pain relief and improvement in function as well as documentation of side effects incurred with use. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects. Within the documentation available for review, there is no identification of any specific analgesic benefit (in terms of percent reduction in pain or reduction of NRS), and no documentation of specific objective functional improvement. In the absence of such documentation, the currently requested Neurontin 300mg #90 is not medically necessary.

**Zanaflex 2mg #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66.

**Decision rationale:** Regarding the request for Zanaflex (tizanidine) 2mg #90, Chronic Pain Medical Treatment Guidelines support the use of nonsedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Guidelines go on to state that tizanidine specifically is FDA approved for management of spasticity; unlabeled use for low back pain. Guidelines recommend LFT monitoring at baseline, 1, 3, and 6 months. Within the documentation available for review, there is no identification of a specific analgesic benefit or objective functional improvement as a result of the tizanidine. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. Finally, it does not appear that there has been appropriate liver function testing, as recommended by guidelines. In the absence of such documentation, the currently requested Zanaflex (tizanidine) 2mg #90 is not medically necessary.