

|                       |              |                              |            |
|-----------------------|--------------|------------------------------|------------|
| <b>Case Number:</b>   | CM15-0003855 |                              |            |
| <b>Date Assigned:</b> | 01/14/2015   | <b>Date of Injury:</b>       | 11/06/2012 |
| <b>Decision Date:</b> | 03/24/2015   | <b>UR Denial Date:</b>       | 12/23/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 01/08/2015 |

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California, Arizona

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 62-year-old male who suffered an electrocution injury on 11/08/2012. The current diagnoses include status post L4-S1 anterior fusion with residual back pain, recent GI bleed, cervical degenerative disc disease and stenosis, right arm radiculopathy, and stomach upset. The injured worker presented on 10/07/2014 for a followup evaluation. It was noted that the injured worker was status post L4-S1 lumbar spine fusion in 12/2013. The injured worker reported persistent low back pain with radiation into the bilateral lower extremities. Previous conservative treatment includes ice therapy, heat therapy, NSAIDs, and physical therapy. Upon examination, there was 2+ paralumbar tenderness, spasm, atrophy in the quadriceps, diminished range of motion, positive straight leg raising at 40 degrees bilaterally, absent deep tendon reflexes at the bilateral ankles, decreased sensation in the lateral thigh, and 5/5 motor strength in the bilateral lower extremities. Recommendations included continuation of the current medication regimen, therapeutic exercise, and a lumbar epidural steroid injection at the L5 level with CPT codes 62310, 76003, 76499, and 01992. There was no Request for Authorization form submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**L5 Caudal steroid injection:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines epidural Steroid Injection (ESIs) Page(s): 49.

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

**Decision rationale:** The California MTUS Guidelines state epidural steroid injections are recommended as an option for patients with radicular pain. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. According to the documentation provided, the injured worker has exhausted conservative treatment. However, there was no objective evidence of dermatomal or myotomal deficits. There is presence of an ongoing 2 level fusion without mention of solid fusion status. Given the above, the request is not medically appropriate at this time.

**Monitored anesthesia care:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Epidurography in outpatient setting:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Norco 325mg #180:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 82-8.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

**Decision rationale:** The California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects

should occur. There was no documentation of a written consent or agreement for chronic use of an opioid. There was no documentation of a failure of nonopioid analgesics. There is also no frequency listed in the request. Given the above, the request is not medically appropriate.

**Flexeril tablet 7.5mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 67. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)- Pain Chapter

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

**Decision rationale:** The California MTUS Guidelines state muscle relaxants are recommended as nonsedating second line options for short term treatment of acute exacerbations. The guidelines do not recommend long term use of muscle relaxants. It is unclear how long the injured worker has utilized Flexeril 7.5 mg. There was also no frequency listed in the request. Given the above, the request is not medically appropriate.

**Ambien 10mg #30:** 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)Formulary/ Pain Chapter: Non-Benzodiazepine Sedative-Hypnotics

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Insomnia Treatment.

**Decision rationale:** The Official Disability Guidelines recommend insomnia treatment based on etiology. Ambien is indicated for the short term treatment of insomnia with difficulty of sleep onset for 7 to 10 days. The injured worker does not maintain a diagnosis of insomnia. There is no documentation of a failure of nonpharmacologic treatment prior to the initiation of Ambien 10 mg. There is also no frequency listed in the request. Given the above, the request is not medically appropriate.

**Diazepam 10mg #120:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 23.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 24.

**Decision rationale:** The California MTUS Guidelines do not recommend benzodiazepines for long term use because long term efficacy is unproven and there is a risk of dependence. The

injured worker does not maintain a diagnosis of anxiety disorder. The medical necessity for a benzodiazepine has not been established in this case. There is also no frequency listed in the request. As such, the request is not medically appropriate.