

<b>Case Number:</b>	CM15-0018039		
<b>Date Assigned:</b>	02/05/2015	<b>Date of Injury:</b>	11/16/2013
<b>Decision Date:</b>	04/02/2015	<b>UR Denial Date:</b>	01/23/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/30/2015

### 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

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 26 year old male, who sustained an industrial injury on 11/16/13. He has reported low back and right leg injury. The diagnoses have included right SI lumbosacral, thoracolumbar sprain/strain with radiculitis. Treatment to date has included pain management, activity restrictions and oral medications. Currently, the injured worker complains of stiffness, burning and stinging on left side. On 12/8/14, the injured worker stated his pain level was slowly getting worse. On 1/23/15 Utilization Review non-certified 1 lumbar epidural steroid injection at L4-5 and L5-S1, noting it is recommended for radicular pain; 12 sessions of physical therapy with pelvic traction; 1 prescription for Horizant 600mg #30, noting it is recommended for treatment of neurological pain, and prior evaluation noted that neurological tests were normal; 1 Medrol dose pak, noting it is recommended for acute radicular pain and the injured worker suffered from chronic pain and 3 urine drug screens in a 12 month period, noting the lack of evidence that opioids were prescribed. The MTUS, ACOEM Guidelines and ODG were cited. On 1/27/15, the injured worker submitted an application for IMR for review of 1 lumbar epidural steroid injection at L4-5 and L5-S1; 12 sessions of physical therapy with pelvic traction, 1 prescription for Horizant 600mg #30; 1 Medrol dose pak and 3 urine drug screens in a 12 month period.

### IMR ISSUES, DECISIONS AND RATIONALES

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

## **1 lumbar epidural steroid injection at L4-L5 and L5-S1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 146-7.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ESI Page(s): 46-47. Decision based on Non-MTUS Citation Official disability guidelines, chapter 'Low Back -Lumbar & Thoracic (Acute & Chronic)' and topic 'Epidural steroid injections (ESIs), therapeutic'.

**Decision rationale:** The patient presents with back pain radiating to the mid-back and bilaterally, into the legs. The request is for 1 LUMBAR EPIDURAL STEROID INJECTION AT L4-L5 and L5-S1. Physical examination to the lumbar spine on 02/09/15 revealed decreased range of motion in all planes. Straight leg test was positive. Patient has had 8 sessions of chiropractic treatment with benefit. Per 02/09/15 progress report, patient's diagnosis includes lumbosacral right SI thoracolumbar sprain/strain with radiculitis. Patient's work status is modified duties. The MTUS Guidelines has the following regarding ESI under chronic pain section page 46 and 47, Recommended as an option for treatment of radicular pain." MTUS has the following criteria regarding ESI's, under its chronic pain section: Page 46,47 "radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing." For repeat ESI, MTUS states, "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." ODG guidelines, chapter 'Low Back -Lumbar & Thoracic (Acute & Chronic)' and topic 'Epidural steroid injections (ESIs), therapeutic', state that At the time of initial use of an ESI (formally referred to as the diagnostic phase as initial injections indicate whether success will be obtained with this treatment intervention), a maximum of one to two injections should be performed. A repeat block is not recommended if there is inadequate response to the first block (< 30% is a standard placebo response). A second block is also not indicated if the first block is accurately placed unless: (a) there is a question of the pain generator; (b) there was possibility of inaccurate placement; or (c) there is evidence of multilevel pathology. In these cases a different level or approach might be proposed. There should be an interval of at least one to two weeks between injections. The patient has radicular symptoms and is diagnosed with lumbosacral right SI thoracolumbar sprain/strain with radiculitis. There are no records of prior ESI injections. Per 02/09/15 progress report, patient went into the ER on 01/21/15 due to increased lower back pain radiating into his legs and received a local injection and medications. MTUS guidelines support ESIs for a clear diagnosis of radiculopathy with radicular symptoms, positive examination and corroborating imaging study. In this case, the patient has leg symptoms with positive SLR but no EMG/NCV or MRI is provided showing nerve root issues. The request IS NOT medically necessary.

## **12 sessions of physical therapy with pelvic traction: 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 Physical medicine Page(s): 98-99.

**Decision rationale:** The patient presents with lower back pain radiating into the mid-back and bilaterally, into his legs. The request is for 12 SESSIONS OF PHYSICAL THERAPY WITH PELVIC TRACTION. Physical examination to the lumbar spine on 02/09/15 revealed decreased range of motion in all planes. Straight leg test was positive. Patient has had 8 sessions of chiropractic treatment with benefit. Per 02/09/15 progress report, patient's diagnosis includes lumbosacral right SI thoracolumbar sprain/strain with radiculitis. Patient's work status is modified duties. Treater has not provided reason for the request, treatment history, nor indicated why patient cannot move on to home therapy program. There are no previous records of physical therapy, thus, a short course of physical therapy would be indicated. However, the request for 12 sessions of physical therapy would exceed guideline recommendation for the patient's condition. Therefore, the request IS NOT medically necessary.

**Horizant 600 mg #30:** 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 Antiepilepsy drugs (AEDs), Gabapentin(Neurontin), Medications for chronic pain Page(s): 18-19, 60.

**Decision rationale:** The patient presents with lower back pain radiating bilaterally into his legs. The request is for HORIZANT 600 MG. Physical examination to the lumbar spine on 02/09/15 revealed decreased range of motion in all planes. Straight leg test was positive. Patient has had 8 sessions of chiropractic treatment with benefit. Per 02/09/15 progress report, patient's diagnosis includes lumbosacral right SI thoracolumbar sprain/strain with radiculitis. Patient's work status is modified duties. MTUS has the following regarding Gabapentin on pg 18,19: "Gabapentin(Neurontin, Gabarone, generic available) has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain." MTUS p60 also states, "A record of pain and function with the medication should be recorded," when medications are used for chronic pain. Treater has not discussed reason for the request. In this case, only four progress reports dated, 08/25/14, 10/20/14, 12/08/14 and 02/09/15, have been provided for review, and none of the reports document the use of Horizant. The patient suffers from back pain radiating into his legs. However, there is no diagnosis of neuropathic pain for which Horizant is indicated. Therefore, the request IS NOT medically necessary.

**Medrol dose pack:** Overturned

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines, low back chapter, oral corticosteroids.

**Decision rationale:** The patient presents with lower back pain radiating bilaterally into his legs. The request is for MEDROL DOSE PACK. Physical examination to the lumbar spine on 02/09/15 revealed decreased range of motion in all planes. Straight leg test was positive. Patient has had 8 sessions of chiropractic treatment with benefit. Per 02/09/15 progress report, patient's diagnosis includes lumbosacral right SI thoracolumbar sprain/strain with radiculitis. Patient's work status is modified duties. Regarding oral corticosteroids, ODG under its low back chapter states not recommended for chronic pain. There is no data on the efficacy and safety of systemic corticosteroids in chronic pain, so given their serious adverse effects, they should be avoided. (Tanner, 2012) ODG Low Back Chapter recommends in limited circumstances for acute radicular pain. Multiple severe adverse effects have been associated with systemic steroid use, and this is more likely to occur after long-term use. Medrol (methylprednisolone) tablets are not approved for pain. (FDA, 2013). Treater has not provided a reason for the request. However, the patient did present to ER with acute flare-up/exacerbation of back and leg symptoms. A course of Medrol Dose pack may be indicated given the patient's acute radicular symptoms. The request IS medically necessary.

**3 urine drug screens in a 12 months period:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Drug testing Page(s): 43. Decision based on Non-MTUS Citation Official disability guidelines Pain chapter, Urine drug testing.

**Decision rationale:** The patient presents with lower back pain radiating bilaterally into his legs. The request is for 3 URINE DRUG SCREENS IN A 12 MONTH PERIOD. Physical examination to the lumbar spine on 02/09/15 revealed decreased range of motion in all planes. Straight leg test was positive. Patient has had 8 sessions of chiropractic treatment with benefit. Per 02/09/15 progress report, patient's diagnosis includes lumbosacral right SI thoracolumbar sprain/strain with radiculitis. Patient's work status is modified duties. MTUS Chronic Pain Medical Treatment Guidelines, for Testing, pg 43 states: Recommended as an option, using a urine drug screen to assess for the use or the presence of illegal drugs. ODG-TWC Guidelines, online, Pain chapter for Urine Drug Testing states: Patients at low risk of addiction/aberrant behavior should be tested within six months of initiation of therapy and on a yearly basis thereafter. There is no reason to perform confirmatory testing unless the test is inappropriate or there are unexpected results. If required, confirmatory testing should be for the questioned drugs only. Treater has not provided a reason for the request. Guidelines indicate that urine drug screening is recommended for monitoring compliance with prescribed medications. However, in review of the medical records provided, there were no indication that the patient was prescribed opioids or other substances that require monitoring. Furthermore, the request is 3 UDS's over a

12 month period. Without a proper opiate risk assessment, frequent UDS's would not be indicated. Therefore, the request IS NOT medically necessary.