

<b>Case Number:</b>	CM15-0130619		
<b>Date Assigned:</b>	07/17/2015	<b>Date of Injury:</b>	08/25/2004
<b>Decision Date:</b>	08/19/2015	<b>UR Denial Date:</b>	06/17/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/07/2015

### 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, Pain Management

### 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 70-year-old female sustained an industrial injury on 8/25/04. She subsequently reported knee and back pain. Diagnoses include internal derangement of the knee, bilateral knee osteoarthritis and lumbar discogenic disease. Treatments to date include x-ray and MRI testing, lumbar fusion surgery, physical therapy and prescription pain medications. The injured worker continues to experience pain in the knees and low back. Upon examination, there was decreased range of motion of bilateral legs with knee pain with extension and flexion. Tenderness is noted in bilateral knee joints. There was spasm in the lumbar spine. Lasegue is positive bilaterally. Tenderness to palpation over the left lumbar paraspinal musculature. Straight leg raise testing was positive to the left at 60 degrees. A request for Norco, Neurontin, (1/2) Inch Shoe Lift and LESI L2-3 bilaterally was made by the treating physician.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Norco 10/325 MG #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 & 9792.26 MTUS (Effective July 18, 2009) Page(s): 44, 47, 75-79, 120 of 127.

**Decision rationale:** Regarding the request for Norco (hydrocodone/acetaminophen), California Pain Medical Treatment Guidelines state that this 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 (in terms of specific examples of functional improvement) and no discussion regarding aberrant use. As such, there is no clear indication for ongoing use of the medication. Opioids should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In light of the above issues, the currently requested Norco (hydrocodone/acetaminophen) is not medically necessary.

**Neurontin 600 MG #90:** 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 & 9792.26 MTUS (Effective July 18, 2009) Page(s): 16-21 of 127.

**Decision rationale:** Regarding request for gabapentin (Neurontin), 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 objective functional improvement. Additionally, there is no discussion regarding side effects from this medication. Antiepileptic drugs should not be abruptly discontinued but unfortunately, there is no provision to modify the current request. As such, the currently requested gabapentin (Neurontin) is not medically necessary.

**(1/2) Inch Shoe Lift:** 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).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Ankle/Foot Chapter, Limb length temporary adjustment device.

**Decision rationale:** Regarding the request for shoe lift, CA MTUS does not address the issue. ODG recommends a heel/sole lift for limb length discrepancy when it is necessary to balance the limb lengths from use of an orthotic device that will add more than 2 cm length to one lower extremity for a long duration. Within the documentation available for review, the patient's discrepancy is less than 2 cm and there is no indication of any specific symptoms/findings attributed to this discrepancy. In light of the above issues, the currently requested shoe lift is not medically necessary.

**LESI L2-3 Bilaterally:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20-9792.26 Page(s): 46 of 127.

**Decision rationale:** Regarding the request for epidural steroid injection, Chronic Pain Medical Treatment Guidelines state that epidural injections are recommended as an option for treatment of radicular pain, defined as pain in dermatomal distribution with corroborative findings of radiculopathy, and failure of conservative treatment. Regarding repeat epidural injections, guidelines state that 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. Within the documentation available for review, there are no recent specific clinical and imaging/electrodiagnostic findings supporting a diagnosis of radiculopathy. In the absence of such documentation, the currently requested epidural steroid injection is not medically necessary.