

<b>Case Number:</b>	CM15-0143980		
<b>Date Assigned:</b>	08/04/2015	<b>Date of Injury:</b>	05/12/1994
<b>Decision Date:</b>	09/08/2015	<b>UR Denial Date:</b>	07/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/24/2015

### 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, Texas, Florida

Certification(s)/Specialty: Anesthesiology, Pain Management, Hospice & Palliative Medicine

### 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 67-year-old male who sustained an industrial injury on 05-12-94. Initial diagnoses are not available. Current diagnoses include lumbar lumbosacral disc degeneration. Diagnostic testing and treatment to date has included radiographic imaging, lumbar surgery, physical therapy, and medication management. Currently, the injured worker complains of constant stabbing low back pain that radiates down the right lower extremity. The pain is aggravated by activity and movement, and he has difficulty sleeping. His pain has worsened since his last visit. Physical examination is remarkable for lumbar spine tenderness with limited range of motion. Pain is significantly increased with flexion and extension. Requested treatments include 1 bilateral L4-S1 Caudal Epidural Steroid Injection, and 1 prescription for Gabapentin 300mg #60. The injured worker is under social security disability. Date of Utilization Review: 07-02-15.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **1 Bilateral L4-S1 Caudal Epidural Steroid Injection: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs).

**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 Bilateral L4-S1 Caudal 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. Guidelines recommend that no more than one interlaminar level, or two transforaminal levels, should be injected at one session. 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 recent subjective complaints or objective examination findings supporting a diagnosis of radiculopathy. Additionally, there are imaging or electrodiagnostic studies corroborating the diagnosis of radiculopathy. However, there is no indication of at least 50% pain relief with associated reduction of medication use for 6 to 8 weeks as well as functional improvement from previous epidural injections. In addition, guidelines do not recommend more than two nerve root levels be done and the current request is for three levels. As such, the currently requested Bilateral L4-S1 Caudal Epidural Steroid Injection is not medically necessary.

**1 Prescription for Gabapentin 300mg #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20-9792.26 Page(s): 16-21 of 127.

**Decision rationale:** Regarding request for gabapentin, Chronic Pain Medical Treatment Guidelines state that antiepilepsy drugs (AEDs) 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. Additionally, there is no discussion regarding side effects from this medication. In the absence of such documentation, the currently requested gabapentin is not medically necessary.