

<b>Case Number:</b>	CM15-0185614		
<b>Date Assigned:</b>	09/25/2015	<b>Date of Injury:</b>	09/08/2009
<b>Decision Date:</b>	11/03/2015	<b>UR Denial Date:</b>	09/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/21/2015

### 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:

This injured worker is a 70-year-old male who reported an industrial injury on 9-8-2009. The medical records noted a second work fall injury in 2011 for which physical therapy helped. His diagnoses, and or impressions, were noted to include: lumbar radiculopathy and spondylitis; lumbar herniated disc; and lumbar degenerative disc disease. No current imaging studies were noted; magnetic imaging studies of the lumbar spine were noted done on 3-4-2013, and compared to studies done on 10-22-2011. Recent toxicology studies were noted done on 5-4-2015, 6-17-2015 & 7-15-2015; the 7-15-2015 results noted an inconsistency with Gabapentin. His treatments were noted to include physical therapy treatment modalities, medication management with toxicology studies, and modified activities. The pain management progress notes of 8-17-2015 reported: a return of low back pain that was constant, radiating, and rated at a 10 out of 10; his low back pain, with spasms, radiated to the bilateral lower extremities, left > right, was aggravated by sitting, sneezing and activities, was relieved by physical therapy and medications; that he refused recommended surgery; and that 3 epidural injections, in the previous 4 years, each reduced his pain for 4 months; he also reported insomnia due to pain. The objective findings were noted to include: tenderness to the bilateral acromioclavicular joints, sub-deltoid bursa, biceps tendons, glenohumeral joints and sternoclavicular joints; tenderness to the bilateral lumbar 3, 4 & 5 facet joints, and lumbar 3, 4 & 5 inter-spinous ligaments, decreased lumbosacral range-of-motion, and decreased lumbar 2-3 & 4-5 muscle strength, and positive bilateral straight leg raise, Yeoman's and hip compression tests; reduced passive movements in the hip-pelvis region, with positive bilateral straight leg raise in supine, sitting and with reverse straight leg raise tests; that his pain was likely to be inflammatory and radicular in nature; and that imaging studies were not reviewed at that visit. The physician's requests for treatment were noted to

include: transforaminal epidural-lumbar, lumbar 5 - sacral 1, bilaterally; no plan for Ketoprofen 10%-Gabapentin 6%-Amitriptyline 2% 240 gram compound cream was noted. The Request for Authorization, dated 9-4-2015, was noted to include an urgent request for: transforaminal epidural-lumbar, lumbar 5 - sacral 1, bilaterally; and Ketoprofen 10%-Gabapentin 6%-Amitriptyline 2%, apply 1-2 pumps (1-2 grams) to affected area 3-4 times daily, #240 grams. Neither the Jan., March, May, or June 2015 pain management progress notes show Ketoprofen 10%-Gabapentin 6%-Amitriptyline 2% 240 gram compound cream being used or ordered. The Utilization Review of 9-14-2015 non-certified the request for a bilateral lumbar 5 - sacral 1 transforaminal epidural injection, and Ketoprofen 10%-Gabapentin 6%-Amitriptyline 2% 240 gram compound cream.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Transforaminal epidural injection L5-S1 bilaterally:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines recommend ESI as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy); however, radiculopathy must be documented on physical examination and corroborated by imaging studies and/or Electrodiagnostic testing, not provided here. Submitted reports have not demonstrated any correlating neurological deficits or remarkable diagnostics to support the epidural injections. In addition, to repeat a LESI in the therapeutic phase, repeat blocks should be based on continued objective documented decreasing pain and increasing functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks. Criteria for repeating the epidurals have not been met or established as the patient continues to treat for chronic pain without functional benefit from previous injections in terms of decreased pharmacological formulation, increased ADLs and decreased medical utilization. There is also no documented failed conservative trial of physical therapy, medications, activity modification, or other treatment modalities to support for the epidural injection. Lumbar epidural injections may be an option for delaying surgical intervention; however, there is no surgery planned or identified pathological lesion noted. The Transforaminal epidural injection L5-S1 bilaterally is not medically necessary or appropriate.

**Ketoprofen 10% Lidocaine 5% Gabapentin 6% Amitriptyline 2% #240gm:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**Decision rationale:** Per MTUS Chronic Pain Guidelines, the efficacy in clinical trials for topical analgesic treatment modality has been inconsistent and most studies are small and of short duration. These medications may be useful for chronic musculoskeletal pain, but there are no

long-term studies of their effectiveness or safety. There is little evidence to utilize topical compound analgesic over oral NSAIDs or other pain relievers for a patient with diffuse spine and joint pain without contraindication in taking oral medications. Submitted reports have not adequately demonstrated the indication or medical need for this topical analgesic to include a compounded NSAID, Lidocaine, anti-depressant and anti-epileptic over oral formulation for this chronic injury without documented functional improvement from treatment already rendered. Guidelines do not recommend long-term use of NSAID without improved functional outcomes attributable to their use. Additionally, Guidelines do not recommend long-term use of this anti-depressant and anti-seizure medications for this chronic injury without improved functional outcomes attributable to their use. The Ketoprofen 10% Lidocaine 5% Gabapentin 6% Amitriptyline 2% #240gm is not medically necessary or appropriate.