

<b>Case Number:</b>	CM15-0048610		
<b>Date Assigned:</b>	03/20/2015	<b>Date of Injury:</b>	03/22/2011
<b>Decision Date:</b>	05/12/2015	<b>UR Denial Date:</b>	03/10/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/13/2015

### 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 63-year-old female who reported an injury on 03/22/2011. The mechanism of injury was cumulative trauma. Prior therapies included acupuncture, at least 24 sessions of physical therapy, and epidural steroid injections, as well as swimming. The documentation of 03/02/2015, revealed the injured worker had low back pain and right knee pain with increasing right knee cap numbness, deep aching, and right lower extremity cramps. The injured worker reported low back pain was 50% better after the lumbar epidural steroid injection on 10/14/2014, and the injured worker had seen the orthopedist on 02/25/2015. The physician was noted to have requested an MRI of the lumbar spine, which was denied and the Orthopedist was to appeal the MRI to rule out L4 disc collapse. The injured worker had a Baker's cyst. The injured worker had swelling of the low back, and low back pain. The injured worker had a flare-up of low back pain. The injury was noted to almost fall 3 times due to the weakness of the right leg and cramping. The injured worker underwent and EMG/NCV of the lumbar spine, which revealed chronic active left S1 radiculopathy and right S1 radiculopathy. The injured worker was utilizing a right cane. The diagnoses included multilevel lumbar disc disease, postop L5-S1 discectomy and posterior fusion on 12/2012, bilateral knee pain, postop right knee partial replacement, 05/12/2014, and varicose veins. The treatment plan included followup with orthopedic consult on 03/24/2015, for possible L4 disc collapse and follow up for possible Epidural Steroid injection. The treatment plan additionally included for the injured worker to keep the appointment with the pain management doctor, and to refill medications Percocet 5/325 mg #90, Zanaflex 4 mg, #60, continue Lidoderm 5% #30, ibuprofen 800 mg 3 times a day #390

and to request 6 additional sessions of physical therapy for flare-up of low back pain. The documentation of 01/05/2015, revealed the injured worker was following up on an orthopedic consult for a possible removal of hardware from L through S, which may cause leg/knee pain or spasms, or another fusion surgery. The injured worker was to decrease Percocet to 5/325 mg #90, and Zanaflex 4 mg #60. The injured worker underwent urine drug screens. The injured worker underwent x-rays of the lumbar spine on 12/16/2014, which revealed dramatic unilateral disc space collapse at L4-5 on the left, with bone to bone contact, which created an uneven vertebral body with compensatory scoliosis superior to this. The narrowing on the left at L4-5 had worsened. There was no gross instability on forward flexion films. The fusion at L5-S1 appeared solid. The oblique views did not reveal any occult spondylosis and there was no spondylolisthesis.

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

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

**Follow-up orthopedic consultation with a doctor:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment in workers Compensation Procedure Summary.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back chapter, Office visits.

**Decision rationale:** The Official Disability Guidelines indicate the need for a clinical office visit with a healthcare provider is individualized based on a review of the injured worker's concerns, signs and symptoms, and clinical stability, as well as reasonable physician judgment. The clinical documentation submitted for review indicated the injured worker was being followed with pain management and had an epidural steroid injection. The injured worker was noted to have increasing right kneecap numbness, deep aching pain, and right lower extremity cramping. The injured worker as noted to almost fall 3 times due to the weakness of the right leg and cramping. This would support the necessity for a follow-up visit with the orthopedist. The x-rays findings also support the necessity. Given the above, the request for follow-up orthopedic consultation with a doctor is medically necessary.

**Percocet 5/325mg #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain, ongoing management Page(s): 60, 78.

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines recommend opioids for the treatment of chronic pain. There should be documentation of

objective functional improvement, an objective decrease in pain, and documentation the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review indicated the injured worker was being monitored for aberrant drug behavior. However, there was a lack of documentation of objective functional benefit, an objective decrease in pain, and documentation the injured worker was being monitored for side effects. The request as submitted failed to indicate the frequency for the red medication. Given the above, the request for Percocet 5/325 mg #90 is not medically necessary.

**Zanaflex 4mg #60:** Upheld

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

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

**Decision rationale:** The California Medical Treatment Utilization Schedule guidelines recommend muscle relaxants as a second line option for the short term treatment of acute low back pain and their use is recommended for less than 3 weeks. There should be documentation of objective functional improvement. The clinical documentation submitted for review does provide evidence that the injured worker has been on this medication for an extended duration of time and there is a lack of documentation of objective improvement. There was a lack of documentation of exceptional factors. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Zanaflex 4 mg #60 is not medically necessary.

**Lidoderm 5% #30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm Page(s): 56, 57.

**Decision rationale:** The California Medical Treatment & Utilization Schedule guidelines indicate that topical lidocaine (Lidoderm) may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). This is not a first-line treatment and is only FDA approved for post-herpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. The clinical documentation submitted for review failed to provide documentation of a trial and failure of first line therapy. There was a lack of documented efficacy for the requested medication. The request as submitted failed to indicate the frequency and body part to be treated. Given the above, the request for Lidoderm 5% #30 is not medically necessary.

**Ibuprofen 800mg #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67.

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines indicate that NSAIDS are recommended for short term symptomatic relief of mild to moderate pain. It is generally recommended that the lowest effective dose be used for all NSAIDs for the shortest duration of time consistent with the individual injured worker treatment goals. There should be documentation of objective functional improvement and an objective decrease in pain. There was a lack of documentation of objective functional improvement and an objective decrease in pain. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the frequency for ibuprofen 800 mg #90 is not medically necessary.

**Additional physical therapy for the lumbar spine #6:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines - Treatment in Workers Compensation, Low Back Procedure.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98, 99.

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines indicate that ten visits of physical therapy are appropriate for the treatment of myalgia, myositis, and radiculitis. There was a lack of documentation of objective functional benefit received from the prior 24 sessions. There was a lack of documentation of exceptional factors to warrant nonadherence to guideline recommendations. There was a lack of documentation of remaining objective functional deficits. Given the above, the request for additional physical therapy for the lumbar spine, #6, is not medically necessary.