

<b>Case Number:</b>	CM15-0084191		
<b>Date Assigned:</b>	05/27/2015	<b>Date of Injury:</b>	04/29/2014
<b>Decision Date:</b>	07/07/2015	<b>UR Denial Date:</b>	04/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/01/2015

### 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: Florida

Certification(s)/Specialty: Family Practice

### 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 50 year old female, who sustained an industrial injury on April 29, 2014. The injured worker's initial complaints and diagnoses are not included in the provided documentation. The injured worker was diagnosed as having lumbar spine sprain/strain with radiculopathy, rule out disc disease. Diagnostic studies to date have included electromyography / nerve conduction velocity studies. Treatment to date has included pain and proton pump inhibitor medication. On November 14, 2014, the injured worker complains of constant, sharp, stabbing lower back pain radiating to her left thigh. Associated symptoms include numbness and tingling, decreased muscle mass and strength, and difficulty sleeping due to pain. Her pain is unchanged. Her current pain level without medication is rated 8/10. The physical exam revealed normal reflexes of the lower extremities, decreased sensation of the left lumbar 1 to lumbar 3 dermatomes, and active movement against gravity with full resistance of the lumbar 2 to sacral 2 myotomes. There was moderate paraspinal tenderness and spasms of thoracic 12 to sacral 1 levels, and decreased lumbar range of motion. The requested treatments include acupuncture, Robaxin and Lidoderm.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lumbar Epidural Steroid Injection, L3-L4, Qty 1, under Fluoroscopy: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back chapter - Epidural Steroid Injections (ESIs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections, page(s) 46 of 127 Page(s): (s) 46 of 127.

**Decision rationale:** MTUS Criteria for the use of Epidural steroid injections: Note: The purpose of ESI is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). 3) Injections should be performed using fluoroscopy (live x-ray) for guidance. 4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections. 5) No more than two nerve root levels should be injected using transforaminal blocks. 6) No more than one interlaminar level should be injected at one session. 7) 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. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007). 8) Current research does not support a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections. Regarding this patient's case, radiculopathy present on physical exam is not corroborated by imaging studies and/or electrodiagnostic testing. This patient had an unremarkable MRI study, and his EMG result is noted to not be definitive. MTUS criteria has not been satisfied. Likewise, this request is not medically necessary.

**Lumbar/ Sacroiliac S1 injection, Qty 1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): table 12-8. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back - Sacroiliac injections.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG 2015 Sacroiliac Joint Blocks.

**Decision rationale:** MTUS guidelines do not address Sacroiliac Joint Injections. Therefore, the ODG was referenced. The ODG states the following: Criteria for the use of sacroiliac blocks: 1. The history and physical should suggest the diagnosis (with documentation of at least 3 positive exam findings as listed above). 2. Diagnostic evaluation must first address any other possible pain generators. 3. The patient has had and failed at least 4-6 weeks of aggressive conservative therapy including PT, home exercise and medication management. 4. Blocks are performed under fluoroscopy. (Hansen, 2003). 5. A positive diagnostic response is recorded as 80% for the duration

of the local anesthetic. If the first block is not positive, a second diagnostic block is not performed. 6. If steroids are injected during the initial injection, the duration of pain relief should be at least 6 weeks with at least > 70% pain relief recorded for this period. 7. In the treatment or therapeutic phase (after the stabilization is completed), the suggested frequency for repeat blocks is 2 months or longer between each injection, provided that at least >70% pain relief is obtained for 6 weeks. 8. The block is not to be performed on the same day as a lumbar epidural steroid injection (ESI), transforaminal ESI, facet joint injection or medial branch block. 9. In the treatment or therapeutic phase, the interventional procedures should be repeated only as necessary judging by the medical necessity criteria, and these should be limited to a maximum of 4 times for local anesthetic and steroid blocks over a period of 1 year. Regarding this patient's case, documentation does not address other possible pain generators. Additionally, it is not apparent in the documentation exactly what conservative measures have been tried and failed. MTUS guidelines are not satisfied. Likewise, this request is not considered medically necessary.

**Initial Acupuncture, 2 times weekly for 3 weeks, 6 sessions:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Acupuncture Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines: Acupuncture guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Online 2015 edition, acupuncture, low back.

**Decision rationale:** ODG Acupuncture Guidelines: Initial trial of 3-4 visits over 2 weeks. With evidence of objective functional improvement, total of up to 8-12 visits over 4-6 weeks (Note: The evidence is inconclusive for repeating this procedure beyond an initial short course of therapy.) Regarding this patient's case, 6 sessions have been requested. Utilization review approved 3 sessions only as a trial as per ODG guidelines. This decision appears reasonable and appropriate. If objective functional benefit is received and documented from the first 3 sessions, additional sessions can be requested. Likewise, this request for 6 sessions of acupuncture is not medically necessary as the request exceeds ODG guideline recommendations.

**Robaxin 750 mg Qty 90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-65.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antispasticity/Antispasmodic Drugs Page(s): (s) 100, 97.

**Decision rationale:** In accordance with the California MTUS guidelines, Robaxin is a muscle relaxant and muscle relaxants are not recommended for the treatment of chronic pain. From the MTUS guidelines: "Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP." Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence." Likewise, this request for Robaxin is not medically necessary.

**Lidoderm patch 5%, Qty 60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm Page(s): 56-57. Decision based on Non-MTUS Citation Official Disability Guidelines: Lidoderm patches.

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

**Decision rationale:** In accordance with California Chronic Pain MTUS guidelines, Lidoderm (topical Lidocaine) may be recommended for localized peripheral pain after there has been a trial of a first-line treatment. The MTUS guideline specifies "tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica" as first line treatments. The provided documentation does not show that this patient was tried and failed on any of these recommended first line treatments. Topical Lidoderm is not considered a first line treatment and is currently only FDA approved for the treatment of post-herpetic neuralgia. Likewise, for the aforementioned reasons, the requested Lidoderm Patches are not medically necessary.