

<b>Case Number:</b>	CM14-0138323		
<b>Date Assigned:</b>	09/05/2014	<b>Date of Injury:</b>	10/21/2010
<b>Decision Date:</b>	09/30/2014	<b>UR Denial Date:</b>	08/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/26/2014

### 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. The expert reviewer is Board Certified in Family Medicine and is licensed to practice in North Carolina. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 57-year-old with a reported date of injury of 10/21/2010. The patient has the diagnosis of lumbar sprain/strain, lumbar degenerative disc disease, lumbago and lumbar spinal stenosis. Past treatment modalities have included epidural steroid injections, physical therapy and pain management. Per the progress reports by the primary treating physician dated 07/18/2014, the patient had complaints of low back pain that radiates to the left leg. The pain is worse than on the previous visit. The patient states that with the pain medication the pain is rated a 6/10 and without the pain medication it is rated a 9/10. The physical exam noted bilateral positive straight leg raise, pain with range of motion and L5 dermatome distribution of the pain greater on the left. Treatment recommendations included repeat epidural steroid injections, continuation of pain medication and a LSO brace.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **Bilateral TFESI (transforaminal epidural steroid injection) at L4-5 #2: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESI) ,( Selective nerve root block/transforaminal), Lumbar.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines epidural steroid injections Page(s): 46.

**Decision rationale:** The Expert Reviewer based his/her decision on the MTUS Chronic Pain Medical Treatment Guidelines, epidural steroid injections, page 46. The Expert Reviewer's decision rationale: The California chronic pain medical treatment guidelines section on epidural steroid injections (ESI) states: Criteria for the use of Epidural steroid injections: This patient has undergone a previous ESI with reported 70% pain relief for over 6 weeks. However the physical exam does not document radiculopathy and there is no diagnostic studies that corroborate the presence of radiculopathy. In addition there is no documentation of improvement in function or a reduction in the need for medication. For these reasons the criteria set forth above has not been met. Therefore the request is not medically necessary.

**Bilateral TFESI (transforaminal epidural steroid injection) at L5-S1 #2:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESI) ,( Selective nerve root block/transforaminal), Lumbar.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines epidural steroid injections Page(s): 46.

**Decision rationale:** The Expert Reviewer based his/her decision on the MTUS Chronic Pain Medical Treatment Guidelines, epidural steroid injections, page 46. The Expert Reviewer's decision rationale: This patient has undergone a previous ESI with reported 70% pain relief for over 6 weeks. However the physical exam does not document radiculopathy and there is no diagnostic studies that corroborate the presence of radiculopathy. In addition there is no documentation of improvement in function or a reduction in the need for medication. For these reasons the criteria set forth above has not been met. Therefore the request is not medically necessary.

**LSO (lumbar sacral orthosis) back brace:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter, back Braces/Lumbar Supports.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

**Decision rationale:** The Expert Reviewer based his/her decision on the MTUS ACOEM Practice Guidelines, Chapter 12 Low Back Complaints, page 301. The Expert Reviewer's decision rationale: The ACOEM chapter on low back complaints and recommended physical methods for treatment of low back pain states; "Lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief." Per the ODG, "lumbar supports are only recommended in the case of compression fracture. There are low quality studies to support the use of a lumbar support for nonspecific back pain. "This patient is past the acute phase of low back pain. With the lack of quality studies that support the use of a back brace for non-specific back pain, the request does not meet guideline recommendations and thus is not medically necessary.

**Percocet 5/325 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 opioids Page(s): 78-84.

**Decision rationale:** The Expert Reviewer based his/her decision on the MTUS Chronic Pain Medical Treatment Guidelines, opioids, page 78-84. The Expert Reviewer's decision rationale: There is no documentation that the long-term use of this medication has resulted in a return to work or improving function. There is documentation that the pain medicines as a whole decrease the pain level but that is not specific to this medication alone. In addition, previous utilization reviews have recommended the weaning of this medication which has failed to be accomplished. Due to these reasons the above criteria for ongoing use and continued use of the medication have not been met. Therefore the request is not medically necessary

**Flector Patch #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics (non-steroidal anti-inflammatory agents (NSAIDs)).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 111-112.

**Decision rationale:** The Expert Reviewer based his/her decision on the MTUS Chronic Pain Medical Treatment Guidelines, topical analgesics, page 111-112. The Expert Reviewer's decision rationale: The California chronic pain medical treatment guidelines section on topical analgesics states; "Recommended as an option as indicated below. Largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed." These agents are applied locally to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, -adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor)." MTUS guidelines also state, "There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Non-steroidal anti-inflammatory agents (NSAIDs): The efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period. Indications: Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-

term use (4-12 weeks)." The long-term use of this medication of greater than 12 weeks is not recommended per the California MTUS, There is no provided documentation that indicates why continued use would be necessary versus other modalities. The medication is also not intended for the use of the spine, hip or shoulder. For these reasons guidelines recommendations have not been met and the request is not medically necessa