

Case Number:	CM15-0179804		
Date Assigned:	09/21/2015	Date of Injury:	08/16/2011
Decision Date:	10/27/2015	UR Denial Date:	09/02/2015
Priority:	Standard	Application Received:	09/14/2015

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: Emergency 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 51-year-old male, who sustained an industrial injury on 8-16-11. The injured worker was diagnosed as having lumbar radiculopathy; chronic low back pain; lumbar joint arthropathy; lumbar post-laminectomy syndrome. Treatment to date has included status post lumbar L5-S1 laminectomy discectomy (3-17-14); physical therapy; medications. Currently, the PR-2 notes dated 4-23-15 indicated the injured worker complains of bilateral low back pain radiating to the bilateral buttocks. The provider documents the injured worker "had a QME on 4-20-15. The patient stopped taking Norco." The provider continues his documentation stating: "Exacerbating factors: Prolonged sitting, lifting, driving. Mitigating factors: Standing, stretching, using lumbar support. Prior medications: Naprosyn, OxyContin, Norco, Gabapentin, Flexeril. Pat medical history: L5-S1 laminectomy and discectomy on 3-15-14." The provider documents a "Focused Musculoskeletal-Spine Examination". He documents "There is tenderness upon palpation of the lumbar paraspinal muscles overlying the bilateral L4-L5, L5-S1 facet joints. Muscle girth is symmetric in all limbs. Peripheral pulses are 2+ bilaterally with normal capillary filling. Lumbar ranges of motion were restricted by pain in all directions. Lumbar extension was worse than lumbar flexion. Lumbar discogenic provocative maneuvers, including pelvic rock, and sustained hip flexion, were positive bilaterally. Muscle stretch reflexes are 1 and symmetric bilaterally in all limbs. Clonus signs are absent bilaterally. Muscle strength is 5 out of 5 in all limbs except for bilateral extensor hallucis longus stretch was 4+ out of 5. Sensation is intact to light touch, pinprick, proprioception, and vibration in all limbs except for decreased sensation in buttocks. The remainder of the visit is unchanged from the previous visit." The provider's

treatment plan included a request for authorization for bilateral L5-S1 lumbar transforaminal epidural steroid injection to treat the injured work's L5 radiculopathy with lower extremity weakness and decreased sensation. The patient has failed physical therapy, NSAIDs and conservative treatments. A Request for Authorization is dated 9-8-15. A Utilization Review letter is dated 9-2-15 and non-certification was for fluoroscopically - guided diagnostic bilateral L4-L5 and bilateral L5-S1 facet joint medial branch block; MRI lumbar spine and Horizant 600mg #60. Utilization Review denied the requested treatment for not meeting the CA MTUS Guidelines. The provider is requesting authorization of fluoroscopically - guided diagnostic bilateral L4-L5 and bilateral L5-S1 facet joint medial branch block; MRI lumbar spine and Horizant 600mg #60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fluoroscopically - guided diagnostic bilateral L4-L5 and bilateral L5-S1 facet joint medial branch block: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Methods, Special Studies, Summary. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back-Lumbar and Thoracic, Facet Joint diagnostic blocks(injections).

Decision rationale: As per ACOEM Guidelines, facet medial branch blocks may be considered for diagnostics purpose in preparation for cervical neurotomies. The evidence to support neurotomies in lumbar region is poor. Official Disability Guidelines were reviewed for criteria that are more specific. Patient does not meet criteria for recommend facet joint diagnostic blocks. ODG criteria are procedure is limited to patient with low back pain that is non-radicular. Patient has noted radicular pain. All progress notes provided documents request is for epidural steroid injections and nothing is mentioned about medial branch block. It is possible that this is a mistaken request. Either way, patient does not meet any criteria for injection request. This request is not medically necessary.

MRI lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies, Summary.

Decision rationale: As per ACOEM Guidelines, imaging studies should be ordered in event of "red flag" signs of symptoms, signs of new neurologic dysfunction, clarification of anatomy prior to invasive procedure or failure to progress in therapy program. Patient does not meet any of these criteria. There are no documented red flag findings in complaints or exam. There is no noted new neurologic dysfunction. Patient has known deficits and known pathology from prior imaging. There is no justification documented for why MRI of lumbar spine was needed. MRI of lumbar spine is not medically necessary.

Horizant 600mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain web.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain: Horizant (gabapentin enacarbil ER).

Decision rationale: Horizant is a specific extended release formulation of Gabapentin. It is not the same as standard Gabapentin. It has only been FDA approved for Restless Leg Syndrome (RLS) and therefore MTUS guidelines do not apply. For specific criteria, Official Disability Guidelines was used. As per ODG, Horizant (Gabapentin enacarbil extended release) is FDA approved for treatment of restless legs syndrome. (FDA, 2011) There is no evidence to support use of Horizant for neuropathic pain conditions or fibromyalgia without a trial of generic Gabapentin regular release. Patient does not have any documentation of RLS and there is no documentation of failure of generic Gabapentin. This request is not medically necessary.