

Case Number:	CM15-0091272		
Date Assigned:	05/15/2015	Date of Injury:	05/26/2011
Decision Date:	07/03/2015	UR Denial Date:	05/08/2015
Priority:	Standard	Application Received:	05/12/2015

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, Pain Management

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 52 year old female, who sustained an industrial injury on 5/26/11. She has reported initial complaints of lumbar spine, right pelvis and right knee injuries from repetitive work. The diagnoses have included right lumbosacral strain and radiculopathy, myofascial pain, right knee pain, right hip pain and question of internal derangement of the right hip. Treatment to date has included medications, activity modifications, cold therapy, right knee viscosupplementation, right knee surgery, chiropractic, physical therapy, aquatic therapy and home exercise program (HEP). Currently, as per the physician need for additional treatment supplemental report dated and comprehensive progress report dated 4/20/15, the injured worker is noted to have pain starting from the right iliolumbar ligaments with radiation of the pain down the right lower extremity (RLE) with numbness and tingling sensations in the right leg. The physical exam reveals decreased lumbar range of motion and there is tenderness, trigger points and muscle spasms to the right iliolumbar ligament. There are trigger points and muscle spasms in the right lumbosacral paraspinal muscles. There is decreased sensation to light touch in the right foot, decreased reflexes in the right ankle and decreased strength with right dorsiflexors and right extensor hallucis longus muscles. There is positive right straight leg raise at 40 degrees. The current medications included Norco, Flexeril, Neurontin and pain patches. The diagnostic testing that was performed included Magnetic Resonance Imaging (MRI) of the lumbar spine dated 12/27/12 reveals lumbar spondylosis, disc desiccation, disc bulge, spurs and annular fissures, posterolateral annular tear, and facet arthrosis. Magnetic Resonance Imaging (MRI) of the right hip dated 12/27/12 reveals that the test is within normal limits. The

electromyography (EMG) /nerve conduction velocity studies (NCV) of the bilateral lower extremities dated 6/6/12 reveals evidence of chronic lumbar radiculopathy. It is noted by the physician that she complains of constant pain in the right low back with radiation to the right hip and thigh and knee with occasional tingling sensation. She describes the right knee pain as unchanged despite surgery with pain on frequent intermittent basis, frequent cracking and popping and occasional swelling and stiffness. She reports that she cannot take Nonsteroidal anti-inflammatory drugs due to an allergy. The physician requested treatments included Flexeril 7.5 MG, Right L5 and S1 epidural steroid injection (ESI), Magnetic Resonance Imaging (MRI) of The Right Hip and Neurontin 600 MG.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flexeril 7.5 MG: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-66.

Decision rationale: Regarding the request for cyclobenzaprine, Chronic Pain Medical Treatment Guidelines support the use of nonsedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Guidelines go on to state that cyclobenzaprine specifically is recommended for a short course of therapy. Within the documentation available for review, there is documentation of an acute exacerbation of chronic pain. The denial letter authorized by requesting provider does indicate that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. Given this, the current request is medically necessary.

Right L5 and S1 ESI: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ESI Page(s): 47.

Decision rationale: Regarding the request for lumbar epidural steroid injection, Chronic Pain Medical Treatment Guidelines state that epidural injections are recommended as an option for treatment of radicular pain, defined as pain in dermatomal distribution with corroborative findings of radiculopathy, after failure of conservative treatment. Guidelines recommend that no more than one interlaminar level or two transforaminal levels should be injected in one session. Within the documentation available for review, there is an appeal letter authored by the requesting provider, which specifies that recent exam showed a positive straight leg raise sign and diminished LE sensation. Lumbar MRI showed degenerative changes including disc bulges at the L4-5, L5-S1 levels. Given this, and the documentation of prior conservative care, the lumbar epidural steroid injection is medically necessary.

MRI of The Right Hip: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Hip & Pelvis Chapter, MRI.

Decision rationale: The CA MTUS & ACOEM do not address hip MRI. The Official Disability Guidelines (ODG) Hip & Pelvis Chapter, MRI (Magnetic Resonance Imaging) states the following regarding hip MRI: "Recommended as indicated below. MRI is the most accepted form of imaging for finding avascular necrosis of the hip and osteonecrosis. (Koo, 1995) (Coombs, 1994) (Cherian, 2003) (Radke, 2003) MRI is both highly sensitive and specific for the detection of many abnormalities involving the hip or surrounding soft tissues and should in general be the first imaging technique employed following plain films. (American, 2003) (Chana, 2005) (Brigham, 2003) (Stevens, 2003) (Colorado, 2001) (Wild, 2002) (Verhaegen, 1999) (Scheiber, 1999) (Helenius, 2006) (Sakai, 2008) (Leunig, 2004) (Armfield, 2006) (Bredella, 2005) MRI seems to be the modality of choice for the next step after plain radiographs in evaluation of select patients with an occult hip fracture in whom plain radiographs are negative and suspicion is high for occult fracture. This imaging is highly sensitive and specific for hip fracture. Even if fracture is not revealed, other pathology responsible for the patient's symptoms may be detected, which will direct treatment plans. (Cannon, 2009) (Nelson, 2005) This study highlights the limitations of radiography in detecting hip or pelvic pathologic findings, including fractures, as well as soft-tissue pathologic findings. MRI shows superior sensitivity in detecting hip and pelvic fractures over plain film radiography. (Kirby, 2010) Indications for imaging: Magnetic resonance imaging: Osseous, articular or soft-tissue abnormalities. Osteonecrosis Occult acute and stress fracture. Acute and chronic soft-tissue injuries. Tumors. Exceptions for MRI: Suspected osteoid osteoma (See CT), Labral tears (use MR arthrography)." The patient reportedly had a normal hip MRI in 2012. In the case of this injured worker, recent hip x-rays are not submitted. The ODG suggest plain x-rays as a first line imaging modality, and this does not appear to have been recently carried out. This request is not medically necessary.

Neurontin 600 MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines AEDs Page(s): 16-21.

Decision rationale: Regarding request for gabapentin (Neurontin), Chronic Pain Medical Treatment Guidelines state that antiepilepsy drugs are recommended for neuropathic pain. They go on to state that a good outcome is defined as 50% reduction in pain and a moderate response is defined as 30% reduction in pain. Guidelines go on to state that after initiation of treatment, there should be documentation of pain relief and improvement in function as well as documentation of side effects incurred with use. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects. Within the documentation available for review, there is no identification of any specific analgesic benefit (in terms of percent

reduction in pain or reduction of NRS), and no documentation of specific objective functional improvement. Instead there is only documentation of improvement in general terms without specific quantification. The currently requested gabapentin (Neurontin) is not medically necessary.