

<b>Case Number:</b>	CM15-0094052		
<b>Date Assigned:</b>	05/20/2015	<b>Date of Injury:</b>	03/17/2014
<b>Decision Date:</b>	07/07/2015	<b>UR Denial Date:</b>	05/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/15/2015

### 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 50 year old male injured worker suffered an industrial injury on 03/17/2014. The diagnoses included lumbar radiculopathy. The diagnostics included lumbar myelogram and computerized tomography. The injured worker had been treated with physical therapy with aquatic therapy, epidural steroid injections, and medications. On 4/28/2015 the treating provider reported the lumbar pain was rated 3 to 7/10 described as intermittent with associated numbness in the lower extremities that improved by 70% with epidural steroid injections. On exam there was decreased lumbar range of motion. The treatment plan included epidural steroid injection, Gabapentin, Melatonin, Physical therapy with aqua therapy and Acupuncture.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**L5-S1 interlaminar epidural steroid injection:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines criteria for the use of epidural steroid injections.

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

**Decision rationale:** 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 is documented by physical exam and imaging studies. He has failed conservative measures. The patient has previously had one block performed and received 70% of pain relief. MTUS criteria is satisfied for a repeat injection procedure. Likewise, this request is medically necessary.

**Gabapentin 300 mg #80 1 refill:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines specific anti-epilepsy drugs.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin Page(s): 49 of 127.

**Decision rationale:** MTUS guidelines state regarding Gabapentin, "Gabapentin is an anti-epilepsy drug (AEDs, also referred to as anti-convulsants), which has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain". Regarding this patient's case, this patient does have neuropathic pain. Utilization review partially certified this medication (no refills) so that the need for refills can be reassessed at a follow up visit to ensure efficacy before continuation. This is a reasonable approach. Likewise, this request for Gabapentin with 1 refill is not medically necessary.

**Melatonin 2 mg #30 1 refill:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), chapter mental illness and stress, sedative hypnotics.

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

**Decision rationale:** MTUS and ACOEM guidelines do not address the use of Melatonin. Therefore, the ODG guidelines were referenced. The ODG states the following with regarding to the use of Melatonin for insomnia. "Melatonin appears to reduce sleep onset latency to a greater extent in people with delayed sleep phase syndrome than in people with insomnia. Delayed sleep phase syndrome is characterized by late sleep onset and wake up time. It results in late wake up time, resulting in excessive daytime sleepiness, insomnia and daytime functional impairment. This may indicate that this substance "re-sets" the endogenous circadian pacemaker rather than as a direct action of somnogenic structures of the brain. Individuals with delayed sleep phase syndrome are distinguished from individuals with insomnia by the presence of circadian abnormality. Melatonin is also used for treatment of rapid eye movement sleep behavior disorder. This is characterized with motor activity during sleep, acting out of dreams, and polysomnography showing increased muscle tone. There is no evidence that melatonin is effective in treating secondary sleep disorders accompanying sleep restriction, such as jet lag and shift work disorder. The literature reporting treatment of chronic insomnia disorder with melatonin remains inconclusive". Regarding this patient's case, he has insomnia. The documentation does not establish the acuity or chronicity of this problem. Likewise, based off of the documentation, this medication is not medically necessary.

**Physical therapy with aqua therapy for low back 18 sessions:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), low back-lumbar and thoracic (acute and chronic).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): (s) 99 of 127.

**Decision rationale:** In accordance with MTUS guidelines, the physical medicine recommendations state, "Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels". Guidelines also state, "Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine". This patient has previously had 12 physical therapy sessions, but now his physician is requesting an additional 18 sessions. The guidelines recommend fading of treatment frequency with transition to a home exercise program, which this request for a new physical therapy plan does not demonstrate. Likewise, this request is not medically necessary.

**Acupuncture for low back 18 sessions:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Acupuncture Medical Treatment Guidelines Page(s): 8-11.

**Decision rationale:** In accordance with California MTUS Acupuncture guidelines "(c) Frequency and duration of acupuncture or acupuncture with electrical stimulation may be performed as follows: (1) Time to produce functional improvement: 3 to 6 treatments. (2) Frequency: 1 to 3 times per week. (3) Optimum duration: 1 to 2 months. (d) Acupuncture treatments may be extended if functional improvement is documented as defined in Section 9792.20(ef)". Section 9792.20 e and f are defined as follows, "(e) "Evidence-based" means based, at a minimum, on a systematic review of literature published in medical journals included in MEDLINE". "(f) "Functional improvement" means either a clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam, performed and documented as part of the evaluation and management visit billed under the Official Medical Fee Schedule (OMFS) pursuant to sections 9789.10-9789.111; and a reduction in the dependency on continued medical treatment". Regarding this patient's case, it is documented that he has previously had acupuncture therapy. But, it is not documented how many sessions he has previously had nor what functional benefit was derived from these sessions. Therefore, without additional information being provided continued acupuncture therapy is not medically necessary at this time.