

<b>Case Number:</b>	CM13-0003204		
<b>Date Assigned:</b>	07/31/2013	<b>Date of Injury:</b>	08/20/2003
<b>Decision Date:</b>	01/13/2014	<b>UR Denial Date:</b>	07/16/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/25/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, and is licensed to practice in California. 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 physician 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 underlying date of injury in this case is 08/20/2003. The treating diagnoses include lumbar radiculopathy, degenerative disc disease with facet arthropathy, lumbar stenosis, and chronic pain syndrome. The medical records provided for review note that the injured worker suffers from an ongoing chronic pain syndrome, and requests for multiple medications as well as a transforaminal epidural injection at L4, L5, and S1. A prior physician review notes that the medical records do not support evidence of functional improvement or reduction of pain level due to medications, or indication for gastrointestinal prophylaxis. It also notes that Zanaflex is indicated for spasticity of an off-label use for back pain and that the guidelines do not support the use of Zanaflex as there is no evidence of spasticity or myofascial pain syndrome. The review also notes that the guidelines do indicate past benefit from injections, but that only two routes should be injected at one time, and therefore an injection should be approved bilaterally at any 2 levels between L4 and S1. A prior procedure note of 07/13/2012 reports transforaminal epidural injections bilaterally at L4, L5, and S1.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Hydrocodone/APAP 10/325mg #135:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines Section on Opioids/Ongoing Pain Management, page 78, recommends "ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects." The medical records at this time do not include such documentation or discussion of the four domains of opioid management and functional benefit from opioids. This request is not supported by the guidelines and records, and so is not medically necessary.

**Omeprazole 20mg #30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines Section on Anti-inflammatory Medications and Gastrointestinal Symptoms, page 68 states to, "determine if the patient is at risk for gastrointestinal events." The medical records at this time do not discuss specific gastrointestinal risk factors requiring prophylaxis in this patient. The guidelines do not support this request, and so it is not certified.

**Tizanidine 4mg #90:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 66.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines Section on Muscle Relaxants, page 66, states that (regarding Tizanidine) "eight studies have demonstrated efficacy for low back pain. One study notes a significant decrease in pain associated with chronic myofascial pain syndrome and the authors recommended its use as a first-line option to treat myofascial pain." In the case of a patient where opioids have been noncertified, Tizanidine is recommended as a first-line medication. A prior reviewer indicated that there was no spasticity in this case. The guidelines do not require spasticity for Tizanidine to be an indication. Rather, this medication is indicated per the guidelines for multiple forms of neuropathic and particularly non-neuropathic pain, which is consistent with this patient's history. A prior reviewer states that this patient does not have myofascial pain, though that would be almost universally found in a patient with a complex chronic pain syndrome such as this. The records and guidelines do support this request, and it is medically necessary.

**Docusate / Sennosides 50/8.6 #60:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 77.

**Decision rationale:** The Medical Treatment Utilization Schedule Section on Opioids/Initiating Treatment, page 77, states that "prophylactic treatment of constipation should be initiated." Since opioids have been noncertified, it is likely that into the future the patient will no longer require laxatives for constipation. However, this transition may be somewhat gradual. The guidelines do support this request, and it is medically necessary.

**One transforaminal epidural steroid injection bilaterally at L4, L5, and S1:** Upheld

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

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

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines Section on Epidural Injections, page 46, recommends that "radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing... 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 6-8 weeks...No more than 2 nerve root levels should be injected using transforaminal blocks." Although the patient has reported improvement from past injections, it is unclear if this patient fundamentally has a lumbar radiculopathy as a condition supporting this treatment. The medical records describe quite diffuse pain, and it is not clear that this patient has symptoms, exam findings, or other diagnostic data in a specific nerve root distribution. Moreover, the guidelines recommend up to two injections at a time, but not three injections as is currently requested. It also appears that the request in this case is by nerve root rather than by foramen level which is somewhat difficult to unambiguously interpret from a terminology perspective. For these reasons, this request is not supported by the guidelines, and is not medically necessary.