

<b>Case Number:</b>	CM13-0032904		
<b>Date Assigned:</b>	06/06/2014	<b>Date of Injury:</b>	02/02/2011
<b>Decision Date:</b>	07/14/2014	<b>UR Denial Date:</b>	10/03/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/08/2013

### 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 Physical Medicine & 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 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 43-year-old male who was injured on 02/02/2011. Mechanism of injury is unknown. Prior treatment history has included epidural steroid injections on 09/25/2012 and 11/27/2012. The patient notes about 50% pain reduction with the injections. Diagnostic studies reviewed include an MRI of the lumbar spine dated 03/04/2013 revealed a central left paracentral annular tear superimposed and mild diffuse spurring and disc bulging at the L1-L2 level. There is no evidence of large herniation or transligamentous extrusion of this or any other lumbar disc level. There is anterior degenerative change at L1-L1 and L2-L3. Progress note dated 09/23/2013 documented the patient had complained of persistent pain in the lower back area. Objective findings on examination revealed the lumbar range of motion region is 70% of normal in flexion. The patient does not complain of increasing pain towards terminal range of motion. There is tenderness in the lumbar paraspinals at L1 and L2 region. Straight leg raising test is negative bilaterally. Sensory examination is intact to light touch and pinprick in all dermatomes in bilateral lower extremities. Utilization report dated 10/03/2013 denied the request for epidural lumbar steroid ejection at L1-L2 and for tramadol. Prior records established there was no pain documented and functional improvement including at least 50% pain relief with associated reduction of medication used for six to eight weeks. There is no evidence based on the guidelines to support the series of three epidural injections, therefore the request is not certified. For the request of tramadol, the records did not establish the failure of the first line medication in this patient to warrant the recommendation of opioid medication.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TRAMADOL (UNKNOWN DOSE AND QUANTITY): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for chronic pain Page(s): 75-94.

**Decision rationale:** According to the CA MTUS Guidelines, Tramadol (Ultram) is a centrally acting synthetic opioid analgesic and it is not recommended as a first-line oral analgesic, it is indicated for moderate to severe pain. The guidelines state opioids may be continued: (a) If the patient has returned to work and (b) If the patient has improved functioning and pain. Furthermore, there is no documentation of prior trial of NSAIDs or Tylenol. The medical records have not demonstrated the requirements for opioid therapy have been met. Therefore, the medical necessity of Tramadol has not been established and is non-certified.

**LUMBAR EPIDURAL STEROID INJECTION AT LEFT L1 AND L2: Upheld**

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

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

**Decision rationale:** As per CA MTUS guidelines, Epidural steroid injections (ESIs) are recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). One of the criteria stated by the guidelines for the use of ESIs for radicular pain management is; "Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants)". The available medical records do not document the failure of the conservative measures to control the patient's pain, which should be addressed with detailed pain and functional assessment. Furthermore, there is no evidence of radicular pain in the left L1 and L2 distribution and SLR is negative in this case. The CA MTUS Chronic Pain Guidelines recommend 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. There is little to no evidence of pain reduction and / or functional improvement associated with reduction of medication for six to eight weeks. Therefore the medical necessity of the requested Lumbar Epidural Corticosteroid Injections at left L1 and L2 has not been established according to the guidelines and non-certified.