

<b>Case Number:</b>	CM13-0050070		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	04/04/2012
<b>Decision Date:</b>	08/07/2014	<b>UR Denial Date:</b>	07/18/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/08/2013

### 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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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 41-year-old male who has filed a claim for lumbar disc displacement associated with an industrial injury date of April 04, 2012. A review of progress notes indicates low back pain, left knee pain, numbness of the bilateral lower extremities after sitting for 2-3 minutes, and difficulty sleeping. Findings include antalgic gait, decreased lumbar range of motion, tenderness over lumbar facet joints, pain with axial loading of the lumbar facet joints, decreased motor strength over the left gastrocnemius and EHL, and positive straight leg raise on the left. Examination of the left knee showed tenderness along the medial joint, decreased range of motion, mild crepitus, and grinding. MRI of the left knee from March 29, 2013 showed prior partial meniscectomy. MRI of the lumbar spine from April 05, 2013 showed L5-S1 disc bulge with mild facet hypertrophy. MRI of the thoracic spine showed minimal degenerative changes and T10-11 possible small left posterolateral and foraminal disc bulge. Treatment to date has included muscle relaxants, Gabapentin, topical NSAIDs, physical therapy, sedatives, TENS, lumbar epidural steroid injection, lumbar facet injection, opioids, and left knee surgery in 2012. Utilization review from July 18, 2013 denied the requests for thoracic epidural injection as there were no findings of radicular pain or failure of conservative treatment; Cyclobenzaprine-Flexeril #90 as this is only recommended for short-term use; Naproxen 550mg #90 as the patient does not have osteoarthritis or ankylosing spondylitis; tramadol/APAP 37.5/325mg #90, Tramadol HCl ER 150mg #30, and Ultram ER 150mg #30 as there was no documentation of efficacy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**THORACIC EPIDURAL INJECTION: 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 stated on page 46 of California MTUS Chronic Pain Medical Treatment Guidelines, there is no support for epidural injections in the absence of objective radiculopathy. Criteria for the use of epidural steroid injections include an imaging study documenting correlating concordant nerve root pathology and conservative treatment. Repeat blocks should only be offered if there is at least 50% pain relief for six to eight weeks following previous injection, with a general recommendation of no more than 4 blocks per region per year. In this case, there is no documentation of thoracic radiculopathy to support this request. Also, the specific levels to which the injections are directed to are not indicated. Therefore, the request for thoracic epidural injection was not medically necessary.

**CYCLOBENZAPRINE- FLEXERIL 7.5MG #90: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines : Cyclobenzaprine (Flexeril) Page(s): 41-42.

**Decision rationale:** California MTUS Chronic Pain Medical Treatment Guidelines state that Cyclobenzaprine is a skeletal muscle relaxant and a CNS depressant that is recommended as a short-course therapy. The effect is greatest in the first 4 days of treatment. The patient has been on this medication since June 2013. There is no documentation of acute exacerbation of pain, or of significant muscle spasms, to support the continued use of this medication. The requesting physician notes that this medication helps the patient sleep, which is not an indication for use of this medication. Also, this medication is not recommended for chronic use. Therefore, the request for Cyclobenzaprine-Flexeril 7.5mg #90 was not medically necessary.

**NAPROXEN SODIUM - ANAPROX 550MG #90: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines : NSAIDs (nonsteroidal anti-inflammatory drugs) Page(s): 67-69.

**Decision rationale:** As stated on pages 67-69 of the California MTUS Chronic Pain Medical Treatment Guidelines, NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain and there is no evidence of long-term effectiveness for pain

or function. Patient has been on this medication since June 2013. There is no documentation regarding symptomatic improvement or objective functional benefits derived from this medication. Additional information is necessary to support the continued use of this medication. Therefore, the request for Naproxen Sodium-Anaprox 550mg #90 was not medically necessary.

**TRAMADOL/APAP 37.5/325MG #90: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines : Opioids, criteria for use; On-Going Management; Acetaminophen (APAP) Page(s): 78-82, 11-12.

**Decision rationale:** As noted on pages 78-82 of the California MTUS Chronic Pain Medical Treatment Guidelines, there is no support for ongoing opioid treatment unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Acetaminophen is indicated for treatment of chronic pain & acute exacerbations of chronic pain. Patient has been on this medication since July 2013. Progress notes indicate decreased pain and some increase in functionality with this medication. However, there is no documentation of the objective functional improvements, or of periodic urine drug screens to monitor medication use. Therefore, the request for Tramadol/APAP 37.5/325mg #90 was not medically necessary.

**TRAMADOL HCL BR 150MG #30: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines : Opioids, criteria for use; On-Going Management Page(s): 78-82.

**Decision rationale:** As noted on pages 78-82 of the California MTUS Chronic Pain Medical Treatment Guidelines, there is no support for ongoing opioid treatment unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The patient has been on this medication since July 2013. There is no documentation regarding symptomatic improvement or objective functional benefits derived from this medication. Progress notes from August 2013 indicate that the patient rarely takes this medication, and since then, this medication was discontinued. Therefore, the request for Tramadol HCl ER 150mg #30 was not medically necessary.

**ULTRAM ER 150MG #30: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines : Opioids, criteria for use; On-Going Management Page(s): 78-82.

**Decision rationale:** As noted on pages 78-82 of the California MTUS Chronic Pain Medical Treatment Guidelines, there is no support for ongoing opioid treatment unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The patient has been on this medication since July 2013. There is no documentation regarding symptomatic improvement or objective functional benefits derived from this medication. Progress notes from August 2013 indicate that the patient rarely takes this medication, and since then, this medication was discontinued. Therefore, the request for Ultram ER 150mg #30 was not medically necessary.