

<b>Case Number:</b>	CM13-0056300		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	10/04/2001
<b>Decision Date:</b>	04/17/2014	<b>UR Denial Date:</b>	11/06/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/22/2013

### 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 Occupational Medicine 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:

According to the records made available for review, this is a 56-year-old male with a 10/4/01 date of injury. At the time of request for authorization for CT Myelogram - Lumbar Spine; Flexeril 7.5mg, #90; L3 and L4 Foraminal Epidural Injection with Fluoroscopy; and Neurosurgical Consultation, there is documentation of subjective (low back pain radiating to the lower extremity with numbness and tingling) and objective (limited lumbar spine range of motion, a positive straight leg raise, 4/5 weakness in the lower extremities, and decreased sensation in the L4 to S1 distribution) findings, imaging findings (CT L/S 7/8/08) report revealed epidural fibrosis obscuring the nerve roots, current diagnoses (chronic low back pain, lumbar degenerative disc disease, and post-laminectomy syndrome), and treatment to date (lumbar epidural steroid injection with decrease in medication use and medications (including on-going use of Flexeril for greater than 3 months)). Regarding CT Myelogram - Lumbar Spine, there is no documentation a diagnosis/condition (with supportive subjective/objective findings) for which a repeat imaging is indicated. Regarding Flexeril 7.5mg, #90, there is no documentation of acute muscle spasm, functional benefit with previous use, and the intention to treat over a short course (less than two weeks). Regarding L3 and L4 Foraminal Epidural Injection with Fluoroscopy, there is no documentation of at least 50-70% pain relief for six to eight weeks and functional response following previous injection. Regarding Neurosurgical Consultation there is no documentation that diagnostic and therapeutic management has been exhausted within the treating physician's scope of practice and a rationale identifying the medical necessity of a neurological consultation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CT Myelogram - Lumbar Spine: 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), Treatment Index, 11th Edition (web), 2013, Low Back, Myelography.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Minnesota Rules, 5221.6100 Parameters for Medical Imaging.

**Decision rationale:** MTUS reference to ACOEM guidelines identifies documentation of red flag diagnoses where plain film radiographs are negative; objective findings that identify specific nerve compromise on the neurologic examination, failure of conservative treatment, and who are considered for surgery, as criteria necessary to support the medical necessity of imaging of lumbar spine. ODG identifies documentation of a diagnosis/condition (with supportive subjective/objective findings) for which a repeat imaging is indicated (such as: To diagnose a suspected fracture or suspected dislocation, to monitor a therapy or treatment which is known to result in a change in imaging findings and imaging of these changes are necessary to determine the efficacy of the therapy or treatment (repeat imaging is not appropriate solely to determine the efficacy of physical therapy or chiropractic treatment), to follow up a surgical procedure, to diagnose a change in the patient's condition marked by new or altered physical findings) as criteria necessary to support the medical necessity of a repeat imaging. Within the medical information available for review, there is documentation of diagnoses of chronic low back pain, lumbar degenerative disc disease, and post-laminectomy syndrome. In addition, there is documentation of previous imaging (CT L/S 7/8/08). However, there is no documentation a diagnosis/condition (with supportive subjective/objective findings) for which a repeat imaging is indicated. Therefore, based on guidelines and a review of the evidence, the request for CT Myelogram - Lumbar Spine is not medically necessary.

**Flexeril 7.5mg, #90: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-64.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Page(s): 41-42. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Muscle relaxants (for pain).

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identifies that Flexeril is recommended for a short course of therapy. ODG identifies that muscle relaxants are recommended as a second line option for short-term (less than two weeks) treatment of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. Within the medical information available for review, there is documentation of diagnoses of diagnoses of chronic low back pain, lumbar degenerative disc disease, and post-laminectomy

syndrome. However, there is no documentation of acute muscle spasm. In addition, given documentation of records reflecting ongoing use of Flexeril, there is no documentation of functional benefit with previous use and the intention to treat over a short course (less than two weeks). Therefore, based on guidelines and a review of the evidence, the request for Flexeril 7.5mg, #90 is not medically necessary.

### **L3 and L4 Foraminal Epidural Injection with Fluoroscopy: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Epidural Steroid Injections (ESIs).

**Decision rationale:** MTUS reference to ACOEM guidelines identifies documentations of objective radiculopathy in an effort to avoid surgery as criteria necessary to support the medical necessity of epidural steroid injections. ODG identifies documentation of at least 50-70% pain relief for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year, as well as decreased need for pain medications and functional response, as criteria necessary to support the medical necessity of additional epidural steroid injections. Within the medical information available for review, there is documentation of diagnoses of chronic low back pain, lumbar degenerative disc disease, and post-laminectomy syndrome. In addition, there is documentation of a previous epidural steroid injection with decreased need for pain medications. However, there is no documentation of at least 50-70% pain relief for six to eight weeks and functional response following previous injection. Therefore, based on guidelines and a review of the evidence, the request for L3 and L4 Foraminal Epidural Injection with Fluoroscopy is not medically necessary.

### **Neurosurgical Consultation: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Consultations. Page(s): 1.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Independent Medical Examinations and consultations, page(s) 127.

**Decision rationale:** MTUS reference to ACOEM guidelines identifies that consultation is indicated to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work, as criteria necessary to support the medical necessity to support the medical necessity of consultation. Within the medical information available for review, there is documentation of diagnosis of chronic low back pain, lumbar degenerative disc disease, and post-laminectomy syndrome. However, given documentation of the associated diagnostic and therapeutic requests, there is no

documentation that diagnostic and therapeutic management has been exhausted within the treating physician's scope of practice. In addition, there is no documentation of a rationale identifying the medical necessity of a neurological consultation. Therefore, based on guidelines and a review of the evidence, the request for Neurosurgical Consultation is not medically necessary.