

<b>Case Number:</b>	CM13-0059960		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	10/01/2002
<b>Decision Date:</b>	04/02/2014	<b>UR Denial Date:</b>	11/01/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/02/2013

### 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 patient is a 62 year old female who was injured on 10/01/2002 history of injury to her lumbar spine due to cumulative lifting. Treatment history included two back surgeries, walker, massage therapy, chiropractic treatment, medications and ESI. Medications include Vicodin, Robaxin, Baclofen, Lyrica and twice a day. MRI of Lumbar Spine without contrast. Impression: 1. Interval L2-L5 decompression laminectomies with interval decreased now moderate L3-L4 central canal stenosis and mild-moderate L2-L3 central canal stenosis. 2. Multilevel interval increased severe degenerative disc disease, disc bulging, and exiting nerve root compression, as described above. No urine analysis was available for review. Clinic note dated 06/19/2013 documented the patient to have complaints of longstanding back pain. Objective findings on exam included: Lumbar Spine Exam: She has a well healed surgical incision. She is tender over the paraspinal musculature. Moderate range of motion restrictions are noted. She does have some balance inequality with ambulation. Peripheral Skeletal Examination: There is no obvious orthopedic functional limitations in the lower extremities. Straight leg raising does provoke back pain on the right and negative on the left. Neurological Examination: Cranial nerves are intact. Motor is 5/5. Sensation is blunted over the right L4 versus L5 distribution. Clinic note dated 08/22/2013 documented the patient to have complaints of low back pain. Objective findings on exam included: Physical Examination: She is an obese female. She is pleasant and cooperative. She does not appear to be demonstrating overt non-physiologic pain behavior or posturing, although she is fairly functionally impaired including having to walk with a walker for any length or distance. On lumbar spine examination she is still tender over the paraspinal musculature. Neurologic examination reveals her motors are 5/5. Sensation is blunted over the right L4 and L5 distributions. Clinic note dated 10/22/2013 documented the patient was in for follow up. She did receive the transforaminal epidural steroid injection on the right of L4-5 and

L5-S1. That did provide great pain relief for about four days. Then she started being more physically active and the pain returned to its prior status. Today on top of the pain in her right leg and low back she also reports pain in her left leg that radiates down the left posterior aspect of her leg into the lateral calf. She states she is still having numbness. Objective findings on exam included: Physical Examination: She is an obese female. She is pleasant and cooperative with no physiologic pain behavior or posturing. She does ambulate with a walker and antalgic gait. She is alert and oriented x 3, no acute distress. Cranial nerves II-XII are grossly intact. She is still tender over the paraspinal musculature. Her motors are grossly 5/5 in the upper and lower extremities. Sensation is blunted over the right and left L5-S1 distributions. She was also tender to palpation over the buttocks bilaterally. Assessment: 1. Lumbar spondylosis. 2. Lumbar radiculopathy. 3. Lumbago. 4. Status post lumbar decompression L2-5.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**one (1) bilateral L5-S1 transforaminal epidural steroid injections:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs), Lumbar.

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

**Decision rationale:** As per CA MTUS guidelines, ESIs are recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). This patient is status post lumbar decompression at L2-5 and had ESI (Epidural Steroid Injection) on the right at L4-5 and L5-S1 with only pain relief for about 4 days. As per guidelines, a 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 to 8 weeks. Thus, the request for one (1) bilateral L5-S1 transforaminal epidural steroid injections is not medically necessary and appropriate.

**a refill of Vicodin:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, Criteria For Use Of Opioids Page(s): 76-82.

**Decision rationale:** Vicodin is recommended for relief of moderate to moderately severe pain. As per CA MTUS guidelines, four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or nonadherent) drug-related behaviors. This patient has chronic lower back pain and has been using this medication chronically. There is no documentation of objective functional improvement, decreased pain

level, or increased functional activities with use of this medication. In fact, a note dated 08/22/2013 indicates the dosage of Vicodin has been increased to 7.5/500 mg 1-4 x/day. Thus guidelines recommend use of drug screening for ongoing management with issues of abuse, addiction or poor pain control. There is no such information available for review. Guidelines also recommend gradual weaning/slow tapering of individuals taking long-term opioids due to risk of withdrawal symptoms. Thus, the request for a refill of Vicodin is not medically necessary and appropriate.

**Parafon Forte:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299,308.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-65.

**Decision rationale:** As per CA MTUS guidelines, muscle relaxants are recommended as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP(Low Back Pain). Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. In this case, this patient has chronic low back pain with persistent muscle spasm. The provider has requested Parafon Forte and wanted to discontinue Robaxin and baclofen because those medications gave her fatigue and drowsiness. The use of this medication is supported by guidelines; however, the dosage and frequency is unknown from the request and records review. Thus, the request for Parafon Forte is not medically necessary and appropriate.