

<b>Case Number:</b>	CM14-0010641		
<b>Date Assigned:</b>	02/26/2014	<b>Date of Injury:</b>	09/16/2013
<b>Decision Date:</b>	07/30/2014	<b>UR Denial Date:</b>	01/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/27/2014

### 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 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:

This is a 53-year-old female with a 9/16/13 date of injury. The mechanism of injury occurred when she hurt her back while loading mailbags into her vehicle at the post office. In a 2/20/14 progress note, the patient complained of daily constant thoracic pain and low back pain with intermittent radiation of symptoms extending to the right buttock and right leg with numbness, tingling, and weakness. The patient had an evaluation for physical therapy, however, it was not granted. She continues to work, but with limitations due to thoracic and lumbar pain. Her pain score is 5/10 without medications and 3/10 with medications. Objective findings: tenderness to palpation of the lumbar paraspinals and lumbar facets, forward flexion is 30; hyperextension is 10, straight leg raise is positive on the right, no paraspinal muscle spasm. An MRI dated 12/26/13 indicated arthritis at L3-4, L4-5, L5-S1, and a bulging disc at L4-5. There is facet arthropathy at L5-S1. Diagnostic impression: lumbago, thoracic/lumbosacral neuritis/radiculitis, lumbosacral spondylosis without myelopathy, degenerative lumbar/lumbosacral intervertebral disc. Treatment to date includes medication management, activity modification and medial branch blocks. A prior Utilization Review decision dated 1/15/14 did not grant the request for Lumbar facet injections at L4-5 and L5-S1 on the right. There is not sufficient objective documentation of axial back pain, such as a positive facet-loading test. Furthermore, there is no documentation of intended surgical intervention with a positive response from the requested injections. Lastly, there is objective documentation of radicular pain on the physical exam, which contraindicates a facet injection. The request for Transforaminal epidural steroid injection at L4-5 was not granted. There is objective documentation of radicular pain on the physical exam, including a positive straight leg raise; however, there is no diagnostic evidence of neuroforaminal stenosis or nerve root impingement at the requested injection level. Furthermore, there is no documentation of loss of sensation in the requested dermatome. The request for

Flexeril was not granted because there was no explicit documentation of muscle spasms on the physical exam.

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

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

#### **Lumbar Facet Injections AT L4-5, L5-S1 on right: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines Low Back Chapter.

**Decision rationale:** CA MTUS supports facet injections for non-radicular facet mediated pain. In addition, ODG criteria for facet injections include documentation of low-back pain that is non-radicular, failure of conservative treatment (including home exercise, PT, and NSAIDs) prior to the procedure for at least 4-6 weeks, no more than 2 joint levels to be injected in one session, and evidence of a formal plan of additional evidence-based activity and exercise in addition to facet joint therapy. However this patient is documented to have neuropathic pain and facet blocks are only supported for axial pain. In addition, it is unclear if the patient has had physical therapy or has failed conservative therapy methods. Therefore, the request for Lumbar Facet Injections At L4-5, L5-S1 On Right was not medically necessary.

#### **Transforaminal Epidural Steroid Injection (TFESI) at L4-5: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46, 300. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: AMA Guides (Radiculopathy).

**Decision rationale:** The California MTUS does not support epidural injections in the absence of objective radiculopathy. In addition, the California MTUS criteria for the use of epidural steroid injections include an imaging study documenting correlating concordant nerve root pathology; and conservative treatment. Furthermore, repeat blocks should only be offered if there is at least 50-70% 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 a 2/20/14 note, objective findings show tenderness to palpation and decreased range of motion but a normal neurological exam. The patient has a recent date of injury, and there is no documentation of failure of conservative therapy. There is also a request for facet blocks, the patient is receiving medial branch blocks, and it is unclear what type of pain this patient is having. Therefore, the request for Transforaminal Epidural Steroid Injection (TFESI) at L4-5 is not medically necessary.

#### **Flexeril 10MG #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (For Pain).

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

**Decision rationale:** According to page 41 of the California MTUS Chronic Pain Medical Treatment Guidelines, Cyclobenzaprine is recommended as an option, using a short course of therapy. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. Treatment should be brief. There is also a post-op use. The addition of Cyclobenzaprine to other agents is not recommended. From the documentation provided, the patient has been on Cyclobenzaprine dating back at least to 9/18/13, if not earlier. In addition, it is not noted in the reports reviewed that muscle spasms are part of the patient's diagnoses. Furthermore, there is no documentation of an acute exacerbation of the patient's chronic pain to support the short-term use of Cyclobenzaprine. Guidelines do not support the long-term use of muscle relaxants due to diminishing efficacy over time and the risk of dependence. Therefore, the request for Cyclobenzaprine 10 mg #60 is not medically necessary.