

<b>Case Number:</b>	CM14-0131561		
<b>Date Assigned:</b>	08/20/2014	<b>Date of Injury:</b>	06/17/2000
<b>Decision Date:</b>	09/24/2014	<b>UR Denial Date:</b>	08/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/18/2014

### 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 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 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 54-year-old female with a 6/17/00 date of injury. The exact mechanism of injury has not been described. On 7/28/14, it was documented that the patient had chronic low back pain with lumbar degenerative disc disease and lumbar facet osteoarthritis. The pain level is 4-5/10 with medications and 9-10/10 without medications. She recently had a radiofrequency rhizotomy on 3/18/14 with great benefit, which provided her with 70% pain relief and pain levels have been stable. Objective exam showed limited lumbar ROM. There was dysesthesia over the lateral left hip, thigh, calf, and foot, as well as the right lower calf and foot. Lumbar MRI on 12/28/12 showed mild-to-moderate facet arthropathy at L3-4. At L4-5 there is a broad-based disc protrusion minimally increased from a prior exam and mild facet arthropathy at L5-S1. There was no high-grade narrowing of the central canal or neural foramen. Diagnostic Impression: Lumbar disc degeneration, Chronic pain syndrome, Lumbosacral radiculitis. Treatment to date: ESI, RFA, medication management, activity modification. A UR decision dated 8/1/14 denied the request for the lumbar ESI based on the fact that there was no evidence of specific objective radiculopathy at the specific left lumbar levels. The physical exam was vague without any specific dermatome distribution. The most recent lumbar MRI did not show any significant nerve root impingement or disc herniation. There were no electrodiagnostic studies. Also, the 3 levels being requested are in excess of the 2 levels supported by guidelines. The Cyclobenzaprine was denied because it appears it is prescribed for long-term use, which is not supported by guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left L3-4, L4-5, L5-S1 transforaminal epidural steroid injection: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines Page(s): 46. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: AMA Guides (Radiculopathy).

**Decision rationale:** CA MTUS does not support epidural injections in the absence of objective radiculopathy. In addition, CA 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. However, there is no description of objective radiculopathy on examination at these levels. The neurological exam is vague and describes dysesthesias along the entire leg. In addition, the lumbar MRI shows no evidence of significant nerve root impingement. It is also noted that the patient has had prior ESIs, and there is no description of the patient's functional response or duration of pain relief, or at which levels the patient previously had ESIs. No more than two levels are to be injected concurrently. Therefore, the request for left L3-4, L4-5, and L5-S1 transforaminal epidural steroid injection was not medically necessary.

**Flexeril 10mg 1 by mouth twice a day as needed, severe spasm #60: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63.

**Decision rationale:** According to page 63 of the Chronic Pain Medical Treatment Guidelines, Flexeril is recommended for a short course of therapy. Limited, mixed-evidence does not allow for a recommendation for chronic use. Cyclobenzaprine is a skeletal muscle relaxant and a central nervous system depressant with similar effects to tricyclic antidepressants. However, there is no description of an acute exacerbation of the patient's chronic pain. The 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 Flexeril 10 mg 1 by mouth twice a day as needed, severe spasm #60 was not medically necessary.