

Case Number:	CM14-0170828		
Date Assigned:	10/23/2014	Date of Injury:	01/27/2011
Decision Date:	11/21/2014	UR Denial Date:	10/14/2014
Priority:	Standard	Application Received:	10/15/2014

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 Emergency 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 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:

Patient with reported date of injury on 1/27/2011. Mechanism of injury is described as lifting a battery and swinging it away. Patient is post L5-S1 bilateral spinal fusion with L5 laminectomy and TLIF cage placement on 8/22/13. Patient has a diagnosis of facet arthropathy of lumbar spine, grade 1 anterolisthesis and herniated disc with neural foraminal narrowing at L2-3, L4-5 and L5-S1 and degenerative disc disease of lumbar spine. Medical reports reviewed. Last report available until 9/9/14. Patient presents with complaints of back pains. Pain is 6/10 and is constant on R side. Pain reportedly worsening. Occasional numbness radiating down to toes. Reports worsening spasms. There are reports that reference home exercise. Objective exam reveals back with healed scar, slight tenderness to palpation of lumbar mid spine, sensation to lower extremities is intact. L EHL and tibialis anterior with noted mild weakness. Range of motion is decreased. Patient had reported transforaminal epidural at bilateral L4-5 on 4/10/13 that reportedly improved pain by 80% for 4-5months. MRI of lumbar spine (8/9/13) revealed degenerative disc disease and facet arthropathy with grade 1 anterolisthesis, neuroforaminal narrowing from L2-S1 from mild to severe. No electrodiagnostic reports of lower extremities were provided for review. Medications include Norco, Norflex, Lidopro and Flexeril. Patient has had ESI, chiropractic and acupuncture with no relief. There is no noted physical therapy noted. Independent Medical Review is for bilateral transforaminal epidural steroid injection (ESI) at L4 and L5 and Flexeril 7.5mg #60. Prior UR on 10/14/14 recommended non-certification. It certified use of Norco.

IMR ISSUES, DECISIONS AND RATIONALES

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

One bilateral transforaminal epidural steroid injection (ESI) at L4 and L5: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections(ESI) Page(s): 46.

Decision rationale: As per MTUS Chronic Pain Guidelines, Epidural Steroid Injections(ESI) may be useful in radicular pain and may be recommended if it meets criteria. Patient's exam and presentation is not consistent with radiculopathy with no documented straight leg raise on exam, no radicular pain and no noted neurological deficits. There is no EMG report supporting radiculopathy. This by itself would make LESI not recommended, however patient also fails basic criteria for ESI. The basic criteria are: 1) Goal of ESI: ESI has no long term benefit. It can decrease pain in short term to allow for increasingly active therapy or to avoid surgery. The documentation states that LESI was to decrease pain and for "diagnostic and therapeutic" first step which is not a criteria. No long term plans were documented. Fails criteria. 2) Unresponsive to conservative treatment. This appears to be a flare up of chronic pain. There is no documented attempt at request for physical therapy. Pt is not on any first line medications for treatment of neuropathic/radicular pain. There is documentation of "rehabilitative" chiropractic which is not defined by the provider as evidence based physical therapy as recognized by MTUS guidelines. Patient has not completed conservative treatment. Fails criteria. As clearly stated in MTUS Chronic pain guidelines, patient has to meet all basic criteria before ESI can be recommended. The treating physician has failed to document an exam consistent with radiculopathy and appropriate first line conservative measures. The request and documentation does not meet criteria and ESI is not medically necessary.

Flexeril 7.5 mg, sixty count: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Section Page(s): 41 and 64.

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

Decision rationale: Cyclobenzaprine or Flexeril is a muscle relaxant. As per MTUS Chronic pain guidelines, it is recommended for muscle spasms. It is recommended in short term use and has mixed evidence for chronic use with no specific recommendation for chronic use. There is no documentation by the provider about objective improvement in muscle spasms. The number of tablets does not meet MTUS recommendation for short term use. Cyclobenzaprine is not medically necessary.