

Case Number:	CM14-0035445		
Date Assigned:	06/23/2014	Date of Injury:	12/26/2008
Decision Date:	11/26/2014	UR Denial Date:	03/10/2014
Priority:	Standard	Application Received:	03/21/2014

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 Occupational Medicine and is licensed to practice in Montana. 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:

The injured worker is a retired police officer with multiple dates of injury including low back injury on 3/16/98, right ankle injury in 2006, right knee injury on 12/7/07 and injury on 9/18/07. The medical records document that he is considered to have cumulative trauma conditions related to his work as a police officer. His current complaints continue for low back pain radiating to the right lower extremity with paresthesias. He also has complaint of ongoing right knee pain. His right ankle condition is resolved. Treatment has included opioid pain medications ibuprofen, citalopram, cyclobenzaprine and lisinopril. On 10/1/12 the hydrocodone was discontinued and tramadol was started. On 12/8/12 treatment with hydrocodone was reinstated and tramadol was recommended for use at bedtime. He did have a transforaminal epidural steroid injection on 11/11/12 which did provide decreased in pain and paresthesia symptoms in the right lower extremity. The treatment note of 2/3/14 shows that the primary treating physician has requested repeat right transforaminal epidural steroid injections at L4-5 and L5-S1, continued Flexmid (cyclobenzaprine) 7.5 mg twice daily #60 and continued tramadol 50 mg at bedtime #30.

IMR ISSUES, DECISIONS AND RATIONALES

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

Repeat Transforaminal Epidural Steroid Injection at Right L4-5 and L5-S1: Overturned

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): 309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Epidural steroid injections

Decision rationale: The MTUS does note that epidural steroid injections are optional for radicular pain to avoid surgery. The ODG guidelines note that lumbar epidural steroid injections are recommended as a possible option for short-term treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy) with use in conjunction with active rehab efforts. Not recommended for spinal stenosis or for nonspecific low back pain. See specific criteria for use below. Radiculopathy symptoms are generally due to herniated nucleus pulposus or spinal stenosis, but ESIs have not been found to be as beneficial a treatment for the latter condition. Chronic duration of symptoms (> 6 months) has also been found to decrease success rates with a threefold decrease found in patients with symptom duration > 24 months. The ideal time of either when to initiate treatment or when treatment is no longer thought to be effective has not been determined. Indications for repeating ESIs in patients with chronic pain at a level previously injected (> 24 months) include a symptom-free interval or indication of a new clinical presentation at the level. No more than two nerve root levels should be injected using transforaminal blocks. If after the initial block/blocks are given (see "Diagnostic Phase" above) and found to produce pain relief of at least 50-70% pain relief for at least 6-8 weeks, additional blocks may be supported. Indications for repeat blocks include acute exacerbation of pain, or new onset of radicular symptoms. The general consensus recommendation is for no more than 4 blocks per region per year. Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response. The medical records indicate that his initial transforaminal epidural steroid injections were performed on 11/11/12. It has now been 24 months since his previous injection. Although it might be debated that documentation is inadequate, the primary treating physician has reported greater than 50% decrease in pain and paresthesias for at least 6 weeks. The injured worker does have electrodiagnostic confirmation of L5 radiculopathy, a clear indication for use of epidural steroid injections. Repeating the right transforaminal epidural steroid injections is not inconsistent with the MTUS guidelines. I am reversing the previous UR decision. The request for repeat right transforaminal epidural steroid injections at L4-5 and L5-S1 is medically necessary.

Continue Tramadol 50mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 91-94.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 75, 78, 93-94.

Decision rationale: The MTUS notes that tramadol is a central acting opioid analgesic that may be used to treat chronic pain and neuropathic pain. The MTUS states that opioids are not recommended as first line therapy for neuropathic pain. Opioids are suggested for neuropathic pain that has not responded to first line recommendations including antidepressants and

anticonvulsants. The MTUS states that reasonable alternatives to opioid use should be attempted. There should be a trial of non-opioid analgesics. When subjective complaints do not correlate with clinical studies a second opinion with a pain specialist and a psychological assessment should be obtained. The lowest possible dose should be prescribed to improve pain and function. Ongoing use of tramadol requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: the least reported pain over the period since the last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Opioid use for chronic pain appears to be effective for short-term pain relief but long-term benefit is unclear. Tramadol specifically is found to have a small benefit (12% decrease in pain intensity baseline) for up to 3 months. No long-term studies allow for recommended use beyond 3 months. The medical records do not support use of tramadol within the MTUS guidelines noted above. Long-term use of tramadol is documented in the records. There is no review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: the least reported pain over the period since the last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Additionally, the injured worker is also taking hydrocodone, another short-acting opioid. The request for tramadol 50 mg #30 is not medically necessary.

Fexmid (Cyclobenzaprine) 7.5mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain) Page(s): 64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-antispasmodics, cyclobenzaprine (Flexmid) Page(s): 64.

Decision rationale: The MTUS notes that cyclobenzaprine (Flexeril) is an antispasmodic medication, recommended for a short course of therapy with the greatest benefit occurring within the first 4 days. Flexeril is not recommended to be used for longer than 2-3 weeks. The medical records indicate continuous use of Flexeril since at least October 2012. The continued use of Flexeril is not consistent with the MTUS guidelines. The request for Flexeril 7.5 mg #60 is not medically necessary.