

<b>Case Number:</b>	CM14-0197636		
<b>Date Assigned:</b>	12/05/2014	<b>Date of Injury:</b>	10/14/2011
<b>Decision Date:</b>	09/24/2015	<b>UR Denial Date:</b>	11/14/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/25/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: California  
 Certification(s)/Specialty: Emergency Medicine

### 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 39-year-old male, who sustained an industrial injury on 10-14-2011. The injured worker was diagnosed as having lumbar post-laminectomy syndrome, status post microdiscectomy and foraminotomy at L4-5 (6-2013), L5-S1 disc protrusion with impingement on the left S1 nerve root and L3-4 disc protrusion and far left posterior lateral disc protrusion resulting in lateral recess stenosis. Treatment to date has included diagnostics, left L5-S1 transforaminal epidural steroid injection on 7-28-2014, and medications. On 11-04-2014, the injured worker complains of continued low back pain with radiation on the left. It was documented that epidural steroid injections were requested dating back to 9-2-2014 and 10-2-2014, without response. He felt better overall with current course of medication (unspecified), but his left leg became weak after standing for longer than 10-15 minutes. Exam of the low back noted limited range of motion, pain with straight leg raising on the left, and decreased strength of the left foot, with difficulty heel and toe walking. Gastrointestinal complaints were not documented. Prior progress notes (2012) documented heartburn-like symptoms with the use of Anaprox, which was discontinued, and treatment for H-pylori with Prevpac. The use of Norco, Zanaflex, and Omeprazole was noted at this time. Magnetic resonance imaging of the lumbar spine (9-18-2014) was referenced. The treatment plan included a lumbar epidural steroid injection and continued Norco and Neurontin. Tizanidine was requested for acute muscle spasms and chronic myofascial pain. A rationale for Omeprazole was not noted. Work status remained total temporary disability. On 8-19-2014, he was seen following his recent lumbar epidural steroid injection and reported decreased pain in his leg and back. Pain was not rated and

it was documented that he felt his back pain had increased cramping sensation. His functional status was not described.

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

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

**Norco 7.5mg/325mg #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78 of 127.

**Decision rationale:** The request is for the use of a medication in the opioid class. The MTUS guidelines state that for ongoing treatment with a pharmaceutical in this class, certain requirements are necessary. This includes not only adequate pain control, but also functional improvement. Four domains have been proposed for management of patients on opioids. This includes pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant drug-related behaviors. In this case, there is inadequate documentation of persistent functional improvement which should eventually lead to medication discontinuation. As such, the request is not medically necessary. All opioid medications should be titrated down slowly in order to prevent a significant withdrawal syndrome.

**Tizanidine 2mg #30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63 of 127.

**Decision rationale:** The request is for the use of a muscle relaxant to aid in pain relief. The MTUS guidelines state that the use of a medication in this class is indicated as a second-line option for short-term treatment of acute exacerbations of low back pain. Muscle relaxants may be effective in reducing pain and muscle tension, which can increase mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain improvement. Efficacy appears to diminish over time, and prolonged use may lead to dependence. (Homik, 2004) Due to inadequate qualifying evidence and prolonged duration of use, the request is not medically necessary. All muscle relaxant medications should be titrated down slowly to prevent an acute withdrawal syndrome.

**Omeprazole 20mg #30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68 of 127.

**Decision rationale:** The request is for the use of a medication in the class of a proton pump inhibitor. This is usually given as an acid reducing medication for patients with esophageal reflux, gastritis, or peptic ulcer disease. It can also be used as a preventative measure in patients taking non-steroidal anti-inflammatories for chronic pain. Unfortunately, they do have certain side effects including gastrointestinal disease. The MTUS guidelines states that patients who are classified as intermediate or high risk, should be treated prophylactically. Criteria for risk are as follows: "(1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA)." Due to the fact the patient does not meet to above stated criteria, the request for use is not medically necessary.

**Repeat Lumbar Epidural Steroid Injection:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46 of 127.

**Decision rationale:** Criteria for the use of Epidural steroid injections: Note: The purpose of ESI is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). 3) Injections should be performed using fluoroscopy (live x-ray) for guidance. 4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections. 5) No more than two nerve root levels should be injected using transforaminal blocks. 6) No more than one interlaminar level should be injected at one session. 7) In the therapeutic phase, 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 six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007) 8) Current research does not support a series of three injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections. In this case, the patient does not meet the criteria set above. This is secondary to an inadequate response to the first block with regards to pain and functional improvement. As such, the request is not medically necessary.