

<b>Case Number:</b>	CM15-0101314		
<b>Date Assigned:</b>	06/03/2015	<b>Date of Injury:</b>	02/24/2004
<b>Decision Date:</b>	07/08/2015	<b>UR Denial Date:</b>	05/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/27/2015

### 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: Physical Medicine & Rehabilitation

### 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 49 year old male who sustained an industrial injury on 02/24/2004. Treatment provided to date has included: physical therapy, deep tissue massage, chiropractic therapy, lumbar injections, and partial lumbar laminectomy. No recent diagnostic tests were provided and no results of recent testing was noted. There were no noted previous injuries or dates of injury, and no noted comorbidities. On 04/03/2015, physician progress report noted complaints of low back pain and bilateral leg pain. Pain is rated as 2 (0-10) and described as decreased, cramping, aching, pins/needles sensation across the low back with occasional radiating numbness, burning, pins/needles into the lateral aspect of the right lower extremity with activities. Additional complaints include constant numbness along with stabbing and burning pain to the outside of the thigh. The pain was reported to be aggravated/increased with prolonged sitting, standing, walking and increased activities, and relieved with lying down with feet elevated, frequent change in position, medications, and sitting in pool/hot tub. Current medications consist of Percocet, gabapentin, and chlorzoxazone. It was also noted that the massage therapy provided good relief of low back pain, and that previous lumbar injections had provided pain relief for about 2 weeks. The physical exam revealed decreased strength and range of motion in the shoulders, decrease4d sensation in the right L5-S1 dermatomes, tenderness to palpation of the lumbar paraspinal musculature with spasms, positive facet loading test bilaterally, tenderness to palpation over the right-sided sacroiliac joint, and full active flexion of the lumbar spine with pain. The provider noted diagnoses of lumbar spondylosis with myelopathy, lumbar stenosis, lumbago, chronic right radiculopathy, and failed low back

syndrome. Plan of care includes naproxen, omeprazole, gabapentin, Percocet, and MRI of the lumbar spine. Requested treatments include: right lumbar transforaminal epidural steroid injections L3-L4, chlorzoxazone, and 6 sessions of deep tissue massage therapy.

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

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

#### **Right Lumbar Transforaminal Epidural Steroid Injections, L3-L4: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ESI Page(s): 46-47. Decision based on Non-MTUS Citation Official disability guidelines Low Back - Lumbar & Thoracic (Acute & Chronic) Chapter states: "Epidural steroid injections (ESIs), therapeutic.

**Decision rationale:** Based on the 04/03/15 progress report provided by treating physician, the patient presents with low back and bilateral leg pain. Patient is status post partial laminectomy at L4-L5 and S1 with microdissection September 2010, artificial disc replacement at L4-L5 and posterior spinal fusion at L5-S1 08/14/14. The request is for right lumbar transforaminal epidural steroid injections, L3-L4. Patient's diagnosis per Request for Authorization form dated 03/06/15 includes lumbar stenosis, lumbago, chronic right L4-5 radiculopathy, and failed low back syndrome. Treatment to date include surgeries, imaging studies, TENS, chiropractic, SCS trial 07/25/14, and medications. Patient's medications include Chlorzoxazone, Percocet and Gabapentin. Patient's work status not available. MTUS Chronic Pain Treatment Guidelines, section on "Epidural steroid injections (ESIs)" page 46 states these are "recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy)." The MTUS Criteria for the use of Epidural steroid injections states: "Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing." In addition, MTUS states that the patient must be "Initially unresponsive to conservative treatment (exercise, physical methods, NSAIDs and muscle relaxants.)" For repeat ESI, MTUS states, "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." ODG-TWC, Low Back - Lumbar & Thoracic (Acute & Chronic) Chapter states: "Epidural steroid injections (ESIs), therapeutic: With discectomy: Epidural steroid administration during lumbar discectomy may reduce early neurologic impairment, pain, and convalescence and enhance recovery without increasing risks of complications. (Rasmussen, 2008) Not recommended post-op. The evidence for ESI for post lumbar surgery syndrome is poor. (Manchikanti, 2012)" Per 03/06/15 report, treater states right-sided L3 and L4 transforaminal ESI "for treatment of right sided radicular leg pain." The patient has undergone epidural steroid injections a few years ago which "did help," "for about two weeks." Physical examination to the lumbar spine on 03/06/15 revealed tenderness to palpation of the lumbar paraspinal musculature with spasms. Decreased sensation in the RIGHT L5-S1 dermatomes, positive facet loading test bilaterally, negative bilateral straight leg raise test. Lumbar Spine CT dated 01/15/15 revealed "moderate to severe bilateral" L3-L4 "neural foraminal narrowing." In this case, treater has documented radiculopathy, but physical examination findings do not support symptoms to corroborate with imaging study provided. There is no mention of radiculopathy or stenosis due to neural foraminal narrowing in

CT report dated 01/15/15. MTUS requires that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Furthermore, repeat injection would not be supported by MTUS without documentation of significant improvement lasting at least 6-8 weeks. Moreover, the patient is status post partial laminectomy at L4-L5. ODG does not recommend postoperative lumbar ESI. This request is not in accordance with guideline indications. Therefore, the request is not medically necessary.

**Chlorzoxazone 500 mg Qty 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 muscle relaxants for pain Page(s): 63-66.

**Decision rationale:** Based on the 04/03/15 progress report provided by treating physician, the patient presents with low back and bilateral leg pain. Patient is status post partial laminectomy at L4-L5 and S1 with microdissection September 2010, artificial disc replacement at L4-L5 and posterior spinal fusion at L5-S1 08/14/14. The request is for Chlorzoxazone 500 mg qty 60. Patient's diagnosis per Request for Authorization form dated 05/04/15 includes lumbar stenosis, lumbago, chronic right L4-5 radiculopathy, and failed low back syndrome. Physical examination to the lumbar spine on 03/06/15 revealed tenderness to palpation of the lumbar paraspinal musculature with spasms. Decreased sensation in the RIGHT L5-S1 dermatomes, positive facet loading test bilaterally, negative bilateral straight leg raise test. Lumbar Spine CT dated 01/15/15 revealed "moderate to severe bilateral" L3-L4 "neural foraminal narrowing." Treatment to date include surgeries, imaging studies, TENS, chiropractic, SCS trial 07/25/14, and medications. Patient's medications include Chlorzoxazone, Percocet and Gabapentin. Patient's work status not available. Regarding muscle relaxants for pain, MTUS Guidelines page 63 states, "Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. Muscle relaxants may be effective in reducing pain and muscle tension and increasing mobility; however, most LBP cases show no benefit beyond NSAID in pain and overall improvement. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. Drugs with the most limited published evidence in terms of clinical effectiveness include chlorzoxazone, methocarbamol, dantrolene and baclofen." Chlorzoxazone has been included in progress reports dated 03/06/15, 04/03/15, and 05/04/15. Per MTUS, duration of use should be short-term (no more than 2-3 weeks). The patient has been on this medication for at least 2 months to UR date of 05/05/15. Furthermore, requested medication is listed as one with the least published evidence of clinical effectiveness. In addition, the request for quantity 60 does not indicate intended short-term use of this medication. This request is not in accordance with guidelines. Therefore, the request is not medically necessary.

**Deep tissue massage, 6 sessions:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Massage/Myotherapy.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines massage therapy Page(s): 60.

**Decision rationale:** Based on the 04/03/15 progress report provided by treating physician, the patient presents with low back and bilateral leg pain. Patient is status post partial laminectomy at L4-L5 and S1 with microdissection September 2010, artificial disc replacement at L4-L5 and posterior spinal fusion at L5-S1 08/14/14. The request is for deep tissue massage, 6 sessions. Patient's diagnosis per Request for Authorization form dated 05/04/15 includes lumbar stenosis, lumbago, chronic right L4-5 radiculopathy, and failed low back syndrome. Physical examination to the lumbar spine on 03/06/15 revealed tenderness to palpation of the lumbar paraspinal musculature with spasms. Decreased sensation in the RIGHT L5-S1 dermatomes, positive facet loading test bilaterally, negative bilateral straight leg raise test. Lumbar Spine CT dated 01/15/15 revealed "moderate to severe bilateral" L3-L4 "neural foraminal narrowing." Treatment to date include surgeries, imaging studies, TENS, chiropractic, SCS trial 07/25/14, and medications. Patient's medications include Chrozozone, Percocet and Gabapentin. Patient's work status not available. The MTUS Guidelines page 60 on massage therapy states that it is recommended as an option and as an adjunct with other recommended treatments such as exercise and should be limited to 4 to 6 visits. Massage is a passive intervention and treatment, dependence should be avoided. Per 04/03/15 report, treater states under history of treatment "physical therapy which did improve his symptoms to a degree, especially with the deep tissue massage he was receiving." Given patients diagnosis, a short course of massage therapy would be indicated by guidelines. However, treater has not provided a medical rationale for the request, nor a precise treatment history. Furthermore, the request for additional 6 sessions of massage therapy would exceed guideline recommendation. Therefore, the request is not medically necessary.