

Case Number:	CM15-0131322		
Date Assigned:	08/18/2015	Date of Injury:	09/05/2012
Decision Date:	09/24/2015	UR Denial Date:	06/30/2015
Priority:	Standard	Application Received:	07/07/2015

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: Maryland, Texas, Virginia

Certification(s)/Specialty: Internal Medicine, Allergy and Immunology, Rheumatology

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 47 year old male who sustained an industrial injury on September 05, 2012. The worker was employed as a carpenter. The accident was described as while working he was lifting heavy forklift forks and felt immediate onset of spasms in the legs described as cramping pains and subsequently underwent spinal surgery which diminished the numbness in the right lower extremity but did not change any of the low back complaints. He stated last working on September 05, 2012. A primary treating follow up dated June 16, 2015 reported subjective complaint of being unable to sit in one position. He changes from standing to sitting and lying down just during examination. He uses a cane to ambulate. There is tenderness to palpation at the lumbosacral junction. He has pain with lumbar extension and flexion with a positive straight leg raise on the right. There is also complaint of numbness and tingling downward in S1 distribution. There is discussion noted regarding medication denials involving neurontin, Prilosec, NSAID, Zanaflex, Duragesic patches and Norco. At primary follow up dated June 11, 2015, there were subjective complaints of low back and right leg pain. He states that the medication regimen offers significant relief of symptom. He states that Gabapentin caused drowsiness and hes stopped taking it. The Duragesic patches and Norco really help with the pain. He gets good relief from the use of Zanaflex for spasms. In addition he complains of pain in the coccyx that prevents him from lying flat. There was note of a prior provider recommending an epidural injection but he no longer sees that doctor. He even stated the pain radiates down bilateral lower extremities. Current medications consisted of: Duragesic patch 25mcg, Norco 10mg 325mg, Omeprazole, Effexor, and Zanaflex. There is note of the worker

experiencing severe gastrointestinal upset from the use of NSAIDs. The following diagnoses were applied: status post lumbar fusion L4-L5-S1 April 2014; prior laminectomy and discectomy at L5-S1 July 2013; posterior disc protrusion per magnetic resonance imaging done October 09, 2013; right laminectomy at L5-S1; scar tissue all around the right side at L5-S1 but no evidence of recurrent residual disc. Medications prescribed this visit: Duragesc patches, Norco, Zanaflex, Omeprazole, and Effexor. There is recommendation to administer a lumbar epidural injection at L5-S1 attempting to reduce some of the right leg pain and follow up in one month. He is prescribed remaining temporarily totally disabled through June 15, 2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar Epidural Steroid Injection, L5-S1 (sacroiliac): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315, Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back & Lumbar & Thoracic (Acute & Chronic), Epidural steroid injections (ESIs), therapeutic.

Decision rationale: MTUS Chronic pain medical treatment guidelines state that epidural steroid injections are "Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). Epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program." There were no medical documents provided to conclude that other rehab efforts or home exercise program is ongoing. Additionally, no objective findings were documented to specify the dermatomal distribution of pain. MTUS further defines the criteria for epidural steroid injections to include: 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. Radiculopathy does appear to be documented with imaging studies. The patient is taking multiple medications, but the progress reports do not document how long the patient has been on these medications and the "unresponsiveness" to the

medications. Additionally, treatment notes do not indicate if other conservative treatments were tried and failed (exercises, physical therapy, etc). As such, the request for Lumbar Epidural Steroid Injection, L5-S1 (sacroiliac) is not medically necessary.

Zanaflex 4 mg Qty 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tizanidine (Zanaflex); Muscle relaxants.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants, Zanaflex Page(s): 63-67.

Decision rationale: Zanaflex is the brand name version of tizanidine, which is a muscle relaxant. MTUS states concerning muscle relaxants "Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. (Chou, 2007) (Mens, 2005) (VanTulder, 1998) (Van Tulder, 2003) (Van Tulder, 2006) (Schnitzer, 2004) (See, 2008) Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. (Homik, 2004) Sedation is the most commonly reported adverse effect of muscle relaxant medications. These drugs should be used with caution in patients driving motor vehicles or operating heavy machinery. Drugs with the most limited published evidence in terms of clinical effectiveness include chlorzoxazone, methocarbamol, dantrolene and baclofen. (Chou, 2004) According to a recent review in American Family Physician, skeletal muscle relaxants are the most widely prescribed drug class for musculoskeletal conditions (18.5% of prescriptions), and the most commonly prescribed antispasmodic agents are carisoprodol, cyclobenzaprine, metaxalone, and methocarbamol, but despite their popularity, skeletal muscle relaxants should not be the primary drug class of choice for musculoskeletal conditions. (See2, 2008)" MTUS further states, "Tizanidine (Zanaflex, generic available) is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain. (Malanga, 2008) Eight studies have demonstrated efficacy for low back pain. (Chou, 2007) One study (conducted only in females) demonstrated a significant decrease in pain associated with chronic myofascial pain syndrome and the authors recommended its use as a first line option to treat myofascial pain. (Malanga, 2002) May also provide benefit as an adjunct treatment for fibromyalgia. (ICSI, 2007)" The medical record states that the worker has been using this medication for over a year with no significant evidence of functional improvement. As such, the request for Zanaflex 4mg Qty 60 is not medically necessary.

Prilosec 20 mg Qty 30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Institute for Health & Clinical Excellence (NICE): Clinical guideline No 141: 2010 June pg 23.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), NSAIDs, GI symptoms & cardiovascular risk.

Decision rationale: MTUS states "Determine if the patient is at risk for gastrointestinal events: (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)." And "Patients at intermediate risk for gastrointestinal events and no cardiovascular disease: (1) A non-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg omeprazole daily) or misoprostol (200 mg four times daily) or (2) a Cox-2 selective agent. Long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture (adjusted odds ratio 1.44)." The medical documents provided do not establish the patient has having documented GI bleeding/perforation/peptic ulcer or other GI risk factors as outlined in MTUS. As such, the request for Prilosec 20mg Qty 30 is not medically necessary.