

<b>Case Number:</b>	CM15-0149084		
<b>Date Assigned:</b>	08/12/2015	<b>Date of Injury:</b>	05/25/1989
<b>Decision Date:</b>	09/21/2015	<b>UR Denial Date:</b>	07/24/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/31/2015

### 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:

This 62 year old man sustained an industrial injury on 5-25-1989. The mechanism of injury is not detailed. Diagnoses include lumbar disc displacement without myelopathy, lumbosacral spondylosis without myelopathy, leg joint pain, shoulder joint pain, cervical disc degeneration, and cervical spondylosis without myelopathy. Treatment has included oral and topical medications. Physician notes dated 7-15-2015 show complaints of unchanged low back and neck pain. The worker received trigger point injections during this visit. Recommendations include lumbosacral orthotic, Norco, MS Contin, Flexeril, avoid NSAIDs, lumbar spine MRI, bilateral lumbar spine medial branch blocks, and follow up in four weeks.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Flexeril 10mg Qty 30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxant (for pain) Page(s): 41-42 and 63-66.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-66.

**Decision rationale:** This patient presents with chronic neck and low back pain. The current request is for Flexeril 10mg Qty 30. The RFA is dated 7/17/15. Treatment has included caudal ESI, right knee arthroplasty (2013), physical therapy, trigger point injections, oral and topical medications. The patient is not working. MTUS pg. 63-66 states: "Muscle relaxants (for pain): Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbation in patients with chronic LBP. 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. Cyclobenzaprine (Flexeril, Amrix, Fexmid, generic available): Recommended for a short course of therapy." MTUS, Chronic Pain Medication Guidelines, Muscle Relaxants, page 63-66: "Carisoprodol (Soma, Soprodal 350, Vanadom, generic available): Neither of these formulations is recommended for longer than a 2 to 3 week period." Abuse has been noted for sedative and relaxant effects. According to progress report 07/15/15, the patient presents with chronic neck and low back pain, "without new neurologic changes, no new weakness, no new sensation changes, no incontinence." Examination of the lower back revealed crepitation, limited motion, muscle cramps, stiffness and antalgic gait. The patient has been prescribed Flexeril since 05/23/14. MTUS recommends Flexeril, only for a short period (no more than 2-3 weeks). This request for additional prescription of Flexeril would exceed guideline recommendations. Therefore, the request IS NOT medically necessary.

#### **Left L4-L5 Medial Branch Nerve Block Qty 1: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter: Medial Branch Block.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, under Facet Joint Diagnostic Blocks.

**Decision rationale:** This patient presents with chronic neck and low back pain. The current request is for Left L4-L5 Medial Branch Nerve Block Qty 1. The RFA is dated 7/17/15. Treatment has included caudal ESI, right knee arthroplasty (2013), physical therapy, trigger point injections, oral and topical medications. The patient is not working. ODG Low Back Chapter, under Facet Joint Diagnostic Blocks states: Recommend no more than one set of medial branch diagnostic blocks prior to facet neurotomy, if neurotomy is chosen as an option for treatment - a procedure that is still considered "under study." Diagnostic blocks may be performed with the anticipation that if successful, treatment may proceed to facet neurotomy at the diagnosed levels. Current research indicates that a minimum of one diagnostic block be performed prior to a neurotomy, and that this be a medial branch block. Although it is suggested that MBBs and intra-articular blocks appear to provide comparable diagnostic information, the results of placebo-controlled trials of neurotomy found better predictive effect with diagnostic MBBs. In addition, the same nerves are tested with the MBB as are treated with the neurotomy. The use of a confirmatory block has been strongly suggested due to the high rate of false positives with single blocks (range of 25% to 40%) but this does not appear to be cost effective or to prevent the incidence of false positive response to the neurotomy procedure itself. According to progress report 07/15/15, the patient presents with chronic neck and low back pain, "without new neurologic changes, no new weakness, no new sensation changes, no incontinence." Examination of the lower back revealed crepitation, limited motion, muscle cramps, stiffness and antalgic gait. ODG recommends Facet Blocks for patients with lumbar

pain that is non-radicular. In this case, the patient continues with low back pain with non-radicular symptoms. There is no indication that the patient has trialed a lumbar facet block in the past; therefore, a trial injection at this junction is supported by MTUS. This request IS medically necessary.

### **Right L4-L5 Medial Branch Block Qty 1: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter: Medial Branch Block.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, under Facet Joint Diagnostic Blocks.

**Decision rationale:** This patient presents with chronic neck and low back pain. The current request is for Right L4-L5 Medial Branch Block Qty 1. The RFA is dated 7/17/15. Treatment has included caudal ESI, right knee arthroplasty (2013), physical therapy, trigger point injections, oral and topical medications. The patient is not working. ODG Low Back Chapter, under Facet Joint Diagnostic Blocks states: Recommend no more than one set of medial branch diagnostic blocks prior to facet neurotomy, if neurotomy is chosen as an option for treatment - a procedure that is still considered "under study". Diagnostic blocks may be performed with the anticipation that if successful, treatment may proceed to facet neurotomy at the diagnosed levels. Current research indicates that a minimum of one diagnostic block be performed prior to a neurotomy, and that this be a medial branch block. Although it is suggested that MBBs and intra-articular blocks appear to provide comparable diagnostic information, the results of placebo-controlled trials of neurotomy found better predictive effect with diagnostic MBBs. In addition, the same nerves are tested with the MBB as are treated with the neurotomy. The use of a confirmatory block has been strongly suggested due to the high rate of false positives with single blocks (range of 25% to 40%) but this does not appear to be cost effective or to prevent the incidence of false positive response to the neurotomy procedure itself. According to progress report 07/15/15, the patient presents with chronic neck and low back pain, "without new neurologic changes, no new weakness, no new sensation changes, no incontinence." Examination of the lower back revealed crepitation, limited motion, muscle cramps, stiffness and antalgic gait. ODG recommends Facet Blocks for patients with lumbar pain that is non-radicular. In this case, the patient continues with low back pain with non-radicular symptoms. There is no indication that the patient has trialed a lumbar facet block in the past; therefore, a trial injection at this junction is supported by MTUS. This request IS medically necessary.

### **MRI of the lumbar spine: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177,178. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back chapter, MRIs (magnetic resonance imaging) (L-spine).

**Decision rationale:** This patient presents with chronic neck and low back pain. The current request is for Left L4-L5 MRI of the lumbar spine. The RFA is dated 7/17/15. Treatment has included caudal ESI, right knee arthroplasty (2013), physical therapy, trigger point injections,

oral and topical medications. The patient is not working. ACOEM Guidelines, chapter 8, page 177 and 178, state "Unequivocal objective findings that identify specific nerve compromise on the neurological examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option." ODG guidelines, Low back chapter, MRIs (magnetic resonance imaging) (L-spine) state that "for uncomplicated back pain MRIs are recommended for radiculopathy following at least one month of conservative treatment." ODG Guidelines do not support MRIs unless there are neurologic signs/symptoms present. "Repeat MRI's are indicated only if there has been progression of neurologic deficit." ODG guidelines further states that "Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (e.g, tumor, infection, fracture, neurocompression, recurrent disc herniation)." According to progress report 07/15/15, the patient presents with chronic neck and low back pain, "without new neurologic changes, no new weakness, no new sensation changes, no incontinence." Examination of the lower back revealed crepitation, limited motion, muscle cramps, stiffness and antalgic gait. Per report 07/15/15, the treater states "lumbar MRI is indicated at this time." The medical file provided for review does not include any discussion of prior MRI of the l-spine. In this case, there is no evidence of any progressive neurologic deficit to warrant an MRI. ODG Guidelines do not support MRI unless there are neurologic signs / symptoms. The patient does not present with any red flags such as myelopathy or bowel / bladder symptoms. Therefore, the requested MRI of the lumbar spine IS NOT medically necessary.