

<b>Case Number:</b>	CM15-0205108		
<b>Date Assigned:</b>	10/22/2015	<b>Date of Injury:</b>	05/26/2010
<b>Decision Date:</b>	12/10/2015	<b>UR Denial Date:</b>	10/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/19/2015

### 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, District of Columbia, Maryland  
 Certification(s)/Specialty: Anesthesiology, Pain Management

### 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 56 year old male, who sustained an industrial injury on 05-26-2010. A review of the medical records indicates that the worker is undergoing treatment for failed back surgery syndrome, grade II anterolisthesis of L5 on S1 secondary to L5 pars defect, multilevel lumbar spondylolisthesis at L4-L5 and L5-S1 and chronic myofascial pain syndrome. Subjective complaints (08-10-2015) included low back pain with spasm and stiffness that was rated as 7-8 out of 10 without medication and 4-5 out of 10 with Morphine. Objective findings (08-10-2015) showed decreased range of motion of the lumbar spine and left hip, severe paravertebral muscle spasm and localized tenderness in the facet joints at L3-S1, strongly positive left sided Patrick's test, localized tenderness in the left gluteal region and increased lumbar lordosis. The plan of care included continued pain medication and home exercises with possible epidural steroid injection if pain became unbearable. There was no documentation of the effectiveness of Flexeril at relieving pain and there were no gastrointestinal complaints documented. Subjective complaints (10-07-2015) included a severe escalation of low back pain shooting down the legs, left more than right with tingling, numbness and paresthesia that was rated as 7-8 out of 10. Objective findings (10-07-2015) included severe paravertebral muscle spasm and localized tenderness of the lumbar spine with reduced range of motion, increased lumbar lordosis, localized tenderness in the left gluteal region, positive left sided stretch test, diminished sensation to light touch along the lateral and medial border of the left leg, painful external rotation of the left hip and decreased motor strength of the left EHL and plantar flexors. Treatment has included Prilosec (since at least 2012) for stomach upset and heartburn, Flexeril

(since at least 2014) for muscle spasms, Morphine, Norco, Neurontin, Norflex, Relafen, lumbar epidural steroid injection, peripheral nerve stimulator, surgery and a home exercise program. The physician noted that due to the severe escalation of low back and left lower extremity pain, left sided L5-S1 transforaminal and caudal epidural steroid injections were being requested. The physician noted that the injured worker had 60-70% pain relief with previous epidurals for a few months as well as functional improvement, however the documentation submitted after the lumbar epidural injection does not support significant pain relief or objective functional improvement after the previous injection. The injured worker underwent right sided L5 and S1 transforaminal epidural steroid injection and L3-L4 translaminar lumbar epidural steroid injection on 05-12-2014 and a progress note two days later indicates that the worker reported some relief of pain after the injection but could not tell the percentage of pain relief. A 06-11-2014 progress note documents a severe escalation of low back pain shooting down the right leg with lumbar paravertebral muscle spasm, tenderness and restricted range of motion. A utilization review dated 10-16-2015 non-certified unknown left (lumbosacral) L5-S1 transforaminal and caudal epidural steroid injections, Flexeril 10 mg Qty 30 and Prilosec 20 mg Qty 30.

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

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

**Unknown left (lumbosacral) L5-S1 transforaminal and caudal epidural steroid injections:**  
Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

**Decision rationale:** Per the MTUS CPMTG epidural steroid injections are used 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 benefit. The criteria for the use of epidural steroid injections are as follows: 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. Per progress report dated 10/7/15, physical exam noted diminished sensations to light touch along lateral and medial border of the left leg. Manual motor strength was 5/5 except left EHL and plantar flexors were 4+/5. MRI of the lumbar spine (date unknown) revealed multilevel lumbar spondylolisthesis at L4-L5 and L5-S1; grade II anterolisthesis of L5 on S1 secondary to L5 pars defect. I respectfully disagree with the UR physician's denial based upon a lack of documented pain relief following epidural steroid injection in 5/2014. Per the medical records, that was a right sided L5-S1 transforaminal steroid injection. This is a request for left sided injection, which is supported by the documentation. The request is medically necessary.

**Flexeril 10 mg Qty 30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Cyclobenzaprine (Flexeril), Muscle relaxants (for pain).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

**Decision rationale:** With regard to muscle relaxants, the MTUS CPMTG 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. (Chou, 2007) (Mens, 2005) (Van Tulder, 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." Regarding Cyclobenzaprine: "Recommended for a short course of therapy. Limited, mixed-evidence does not allow for a recommendation for chronic use. Cyclobenzaprine is a skeletal muscle relaxant and a central nervous system depressant with similar effects to tricyclic antidepressants (e.g. amitriptyline). Cyclobenzaprine is more effective than placebo in the management of back pain, although the effect is modest and comes at the price of adverse effects." Per p41 of the MTUS guidelines the effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. Treatment is recommended for the treatment of acute spasm limited to a maximum of 2-3 weeks. UDS that evaluate for cyclobenzaprine can provide additional data on whether the injured worker is compliant, however in this case there is no UDS testing for cyclobenzaprine. The documentation submitted for review indicates that the injured worker has been using this medication since at least 4/2014. There is no documentation of the patient's specific functional level or percent improvement with treatment with cyclobenzaprine. As it is recommended only for short-term use, medical necessity cannot be affirmed. The request 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 Official Disability Guidelines: Pain (Chronic) - Proton pump inhibitors (PPIs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

**Decision rationale:** In the treatment of dyspepsia secondary to NSAID therapy, the MTUS recommends stopping the NSAID, switching to a different NSAID, or considering the use of an H2-receptor antagonist or a PPI. The MTUS Chronic Pain Medical Treatment Guidelines recommend the use of proton pump inhibitors in conjunction with NSAIDs in situations in which the patient is at risk for gastrointestinal events including: (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). CPMTG guidelines further specify: "Recommendations: Patients with no risk factor and no cardiovascular disease: Non-selective NSAIDs OK (e.g., ibuprofen, naproxen, etc.) 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 g 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). Patients at high risk for gastrointestinal events with no cardiovascular disease: A Cox-2 selective agent plus a PPI if absolutely necessary. Patients at high risk of gastrointestinal events with cardiovascular disease: If GI risk is high the suggestion is for a low-dose Cox-2 plus low dose Aspirin (for cardioprotection) and a PPI. If cardiovascular risk is greater than GI risk the suggestion is naproxyn plus low-dose aspirin plus a PPI. (Laine, 2006) (Scholmerich, 2006) (Nielsen, 2006) (Chan, 2004) (Gold, 2007) (Laine, 2007)" As there is no documentation of peptic ulcer, GI bleeding or perforation, or cardiovascular disease in the records available for my review, the injured worker's risk for gastrointestinal events is low, as such, medical necessity cannot be affirmed. The request is not medically necessary.