

<b>Case Number:</b>	CM15-0211835		
<b>Date Assigned:</b>	10/30/2015	<b>Date of Injury:</b>	07/19/2006
<b>Decision Date:</b>	12/31/2015	<b>UR Denial Date:</b>	10/28/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/28/2015

### 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: New York

Certification(s)/Specialty: Anesthesiology

### 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 54 year old male injured worker suffered an industrial injury on 7-19-2006. The diagnoses included chronic pain, lumbar facet arthropathy and lumbar radiculitis. On 7-13-2015, the injured worker reported the pain kept him from sexual relations. The provider recommended Viagra for erectile dysfunction. On 10-5-2015, the provider reported low back pain that was constant. He described the pain as severe. The lower extremity pain was in the right hip. The pain was rated 6 out of 10 on average with medication and 9 out of 10 on average without medication. The injured worker reported no improvement from the facet rhizotomy. On exam, the lumbar spine had spasms with tenderness along with moderately to severely limited range of motion. Facet signs were present. The provider noted in the past month pain had kept the injured worker from sexual relations. The provider also noted the Viagra was beneficial with intended effect at prescribed dose. Lidoderm patch was recommended at that visit to the lumbar spine. Flexeril had been in use at least since 4-6-2015. Prior treatments included lumbosacral facet rhizotomy 6-26-2015. The medical record did not include an evaluation for the etiology of the erectile dysfunction with appropriate laboratory studies or evidence of focused clinical history. The documentation provided did not include efficacy for the Flexeril. There was no evidence of a first-line trial of antidepressants prior to trial of Lidoderm. Utilization Review on 10-28-2015 determined non-certification for Right L4-5 lumbar interlaminar epidural steroid injection under fluoroscopy guidance Qty: 1.00, Left L4-5 lumbar interlaminar epidural steroid injection under fluoroscopy guidance Qty: 1.00, Cyclobenzaprine 10mg Qty: 30.00, Viagra 100mg Qty: 2.00 and Lidoderm 5% patch Qty: 30.00.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Right L4-5 lumbar interlaminar epidural steroid injection under fluoroscopy guidance**

**Qty: 1.00:** Upheld

**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 based on Non-MTUS Citation Official Disability Guidelines (ODG) Epidural steroid injections (ESIs).

**Decision rationale:** Epidural steroid injections (ESIs) are recommended as an option for treatment of radicular pain (defined as pain in a dermatomal distribution with corroborative findings of radiculopathy). ESIs can offer short-term pain relief and use should be in conjunction with other rehab efforts. The purpose of ESIs 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. Most current guidelines recommend no more than 2 epidural steroid injections. Current recommendations suggest a second epidural injection if partial success is produced with the first injection, and a third epidural steroid injection is rarely recommended. The CA MTUS guidelines state radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electro-diagnostic testing. The patient must be initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). In this case, there are no reported neurological findings or reported pain in a dermatomal pattern consistent with radiculopathy. Medical necessity for the requested right L4-5 interlaminar ESI under fluoroscopy guidance has not been established. The requested ESI is not medically necessary.

### **Left L4-5 lumbar interlaminar epidural steroid injection under fluoroscopy guidance**

**Qty: 1.00:** Upheld

**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 based on Non-MTUS Citation Official Disability Guidelines (ODG) Epidural steroid injections (ESIs).

**Decision rationale:** Epidural steroid injections (ESIs) are recommended as an option for treatment of radicular pain (defined as pain in a dermatomal distribution with corroborative findings of radiculopathy). ESIs can offer short-term pain relief and use should be in conjunction with other rehab efforts. The purpose of ESIs 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. Most current

guidelines recommend no more than 2 epidural steroid injections. Current recommendations suggest a second epidural injection if partial success is produced with the first injection, and a third epidural steroid injection is rarely recommended. The CA MTUS guidelines state radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electro-diagnostic testing. The patient must be initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). In this case, there are no reported neurological findings or reported pain in a dermatomal pattern consistent with radiculopathy. Medical necessity for the requested left L4-5 interlaminar ESI under fluoroscopy guidance has not been established. The requested ESI is not medically necessary.

**Cyclobenzaprine 10mg Qty: 30.00: Upheld**

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

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

**Decision rationale:** According to the reviewed literature, Cyclobenzaprine (Flexeril) is closely related to the tricyclic antidepressants. It is not recommended for the long-term treatment of chronic pain. This medication has its greatest effect in the first four days of treatment. Guidelines state that this medication is not recommended to be used for longer than 2-3 weeks. According to CA MTUS Guidelines, muscle relaxants are not considered any more effective than non-steroidal anti-inflammatory medications alone. In this case, there are no muscle spasms documented on physical exam. There is no documentation of objective functional improvement from any previous use of this medication. Based on the currently available information, the medical necessity for this muscle relaxant medication has not been established. The requested medication is not medically necessary.

**Viagra 100mg Qty: 2.00: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medscape Internal Medicine (2014).

**Decision rationale:** Sildenafil (Viagra) is a medication used to treat erectile dysfunction and pulmonary arterial hypertension. It acts by inhibiting cGMP-specific phosphodiesterase type 5 (PDE5), an enzyme that promotes degradation of cGMP, which regulates blood flow in the penis. In this case, there is no documentation of testosterone levels, usage of antidepressants, functional improvement from prior usage of this medication, or other urologic etiologies. Medical necessity for the requested medication has not been established. The requested medication is not medically necessary.

**Lidoderm 5% patch Qty: 30.00: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**Decision rationale:** According to the California MTUS Guidelines, topical analgesics, such as Lidoderm patches, are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control, for example, NSAIDs, opioids, or antidepressants. Lidoderm is the brand name for a Lidocaine patch. Topical Lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tricyclic or SNRI anti-depressants, or an AED, such as Gabapentin or Lyrica). Lidoderm patches are not a first-line treatment and are only FDA approved for post-herpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. In addition, this medication is not generally recommended for treatment of osteoarthritis or treatment of myofascial pain/trigger points. Medical necessity of the requested medication has not been established. The requested topical analgesic is not medically necessary.