

<b>Case Number:</b>	CM14-0147495		
<b>Date Assigned:</b>	09/15/2014	<b>Date of Injury:</b>	01/21/1998
<b>Decision Date:</b>	10/16/2014	<b>UR Denial Date:</b>	08/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/11/2014

### 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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation & Pain Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 reported an injury on 01/21/1998. The mechanism of injury was not submitted for clinical review. The diagnoses included status post lumbar fusion, chronic pain, reactive dysphoria, right knee pain status post-surgical intervention, left sacroiliac joint dysfunction, left sided radiculopathy, L3-4 disc degeneration with bilateral severe neural foraminal stenosis. Previous treatments included medication, surgery, chiropractic care, rhizotomy, and MRI. Within the clinical note dated 08/21/2014, it was reported the injured worker complained of intermittent left leg weakness, occasionally both legs. He complained of more pain in his left leg. The injured worker rated his low back pain 3/10 to 6/10 in severity with medication, and 4/10 to 7/10 in severity without medication. He described the pain as a burning sensation from the knee down bilaterally. Upon the physical examination, the provider noted the injured worker had lumbar flexion at 50% and extension at 25%. The deep tendon reflexes were 2+ on the right and left knee. The provider noted muscle triggers upper gluteal bilaterally with twitch response and radiation. The injured worker had left sided sacroiliac joint pain. There was a positive straight leg raise on the clinical documentation. The injured worker had bilateral mild thoracic muscle spasms. The provider requested an epidural, Percocet, tizanidine, Lyrica, Zanaflex; however, a rationale was not submitted for clinical review. The Request for Authorization was submitted and dated on 08/05/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Epidural at L3-4:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESI) Page(s): 46.

**Decision rationale:** The California MTUS Guidelines recommend epidural steroid injections as an option for the treatment of radicular pain, defined as pain in a dermatomal distribution with corroborative finding of radiculopathy. The guidelines note that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic studies, be initially unresponsive to conservative care, exercise, physical methods, NSAIDS, or muscle relaxants. The guidelines recommend if epidural steroid injections are used for diagnostic purposes, a maximum of 2 injections should be performed. There is a lack of imaging studies to corroborate the diagnosis of radiculopathy. There is a lack of documentation indicating the injured worker had been unresponsive to conservative treatment. Additionally, there is lack of significant neurological deficits, such as decreased sensation or motor strength in a specific dermatomal or myotomal distribution. Therefore, Epidural at L3-4 is not medically necessary.

**Percocet 10/325mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, On-Going Management Page(s): 78.

**Decision rationale:** The California MTUS Guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines recommend the use of a drug urine screen or inpatient treatment with issues of abuse, addiction, or poor pain control. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Additionally, the provider failed to document an adequate and complete physical examination, including a pain assessment. Therefore, Percocet 10/325mg #90 is not medically necessary.

**Tizanidine 4mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63,64.

**Decision rationale:** The California MTUS Guidelines recommend non-sedating muscle relaxants with caution as a second line option for short term treatment of acute exacerbation in patients with chronic low back pain. The guidelines do not recommend the use of the medication to be longer than 2 to 3 weeks. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Additionally, the injured worker has been utilizing the medication since 07/2014, which exceeds the guideline recommendation of short term use. Therefore, Tizanidine 4mg #60 is not medically necessary.

**Lyrica 50mg #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti -epilepsy Drugs.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy drugs (AEDs), Page(s): 16,19.

**Decision rationale:** The California MTUS Guidelines recommend Lyrica for neuropathic pain, pain due to nerve damage. The guidelines note Lyrica has been documented to be effective in the treatment of diabetic neuropathy and postherpetic neuralgia, and has FDA approval for both indications, and is considered a first line treatment for both. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Therefore, Lyrica 50mg #30 is not medically necessary.

**Zanaflex 4mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63,64.

**Decision rationale:** The California MTUS Guidelines recommend non-sedating muscle relaxants with caution as a second line option for short term treatment of acute exacerbation in patients with chronic low back pain. The guidelines do not recommend the use of the medication to be longer than 2 to 3 weeks. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The request submitted failed to provide the frequency of the medication. Additionally, the injured worker has been utilizing the medication since 07/2014, which exceeds the guideline recommendation of short term use. Therefore, Zanaflex 4mg #60 is not medically necessary.