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| Case Number: | CM15-0113787 | | |
| Date Assigned: | 06/22/2015 | Date of Injury: | 06/25/2013 |
| Decision Date: | 07/21/2015 | UR Denial Date: | 05/13/2015 |
| Priority: | Standard | Application Received: | 06/12/2015 |

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: Arizona, California
 Certification(s)/Specialty: Family Practice

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 52 year old, female who sustained a work related injury on 6/25/13. The diagnoses have included chronic pain, failed lumbar back surgery syndrome, lumbar post laminectomy syndrome, lumbar radiculopathy, lumbar spondylolisthesis and lumbar herniated nucleus pulposus. Treatments have included medications, a previous lumbar transforaminal epidural steroid injection and acupuncture. In the Pain Medicine Re-Evaluation note dated 4/27/15, the injured worker complains of low back pain. The pain radiates down both legs. She has pain in her buttocks. She rates her pain level an average of 3/10 with medications since last visit. She rates her pain level an average of 5-6/10 without medications since last visit. She states no change in pain since last visit. She has some limitations due to pain in performing activities of living. She has tenderness to palpation of lumbar paravertebral area. She has spasm noted. She has decreased range of motion in lumbar spine. She has positive straight leg raises at 45 degrees seated with both legs. She had a lumbar transforaminal epidural steroid injection on 2/20/15. She had 50-80% overall improvement. She reports good functional improvement. It lasted 3 days. The treatment plan includes a request for a lumbar transforaminal epidural steroid injection and refills of medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left L4-S1 transforaminal epidural injection, under fluoroscopy: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), low back chapter, epidural steroid injection.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines epidural injections Page(s): 47.

Decision rationale: According to the guidelines, the criteria for the use of Epidural steroid injections: Note: The purpose of ESI 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. 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. According to the ACOEM guidelines, invasive procedures such as ESI are not recommended due to their short-term benefit. In this case, the claimant had an ESI a few months ago for which pain relief lasted 3 days and would support the ACOEM claim. As a result, the request for another ESI is not medically necessary.

Cyclobenzaprine 10 mg #30 1 refill: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines cyclobenzaprine (flexeril).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines muscle relaxants6 Page(s): 63.

Decision rationale: According to the MTUS guidelines, Cyclobenzaprine (Flexeril) is more effective than placebo for back pain. It is recommended for short course therapy and has the greatest benefit in the first 4 days suggesting that shorter courses may be better. Those with fibromyalgia were 3 times more likely to report overall improvement, particularly sleep. Treatment should be brief. There is also a post-op use. The addition of Cyclobenzaprine to other agents is not recommended. The claimant had been on Flexeril over a year in combination with opioids. Continued and chronic use is not recommended and not medically necessary.

