

<b>Case Number:</b>	CM15-0123410		
<b>Date Assigned:</b>	07/07/2015	<b>Date of Injury:</b>	04/10/2013
<b>Decision Date:</b>	09/22/2015	<b>UR Denial Date:</b>	06/03/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/26/2015

### 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:

The injured worker is a 55 year old female, who sustained an industrial injury on 4/10/2013. The mechanism of injury was not noted. The injured worker was diagnosed as having lumbar herniated nucleus pulposus, right sciatica, and myofascial pain syndrome. Treatment to date has included diagnostics, physical therapy, and medications. Currently, the injured worker complains of low back pain radiating to the right leg, rated 7-8/10 and unchanged. Her work status was total temporary disability. Objective findings included spasm and decreased range of motion. Reduced sensation was noted to the right L5-S1 distribution. Straight leg raise test was positive on the right. The treatment plan included lumbar epidural steroid injections x3, lumbar trigger point injections x3, bilateral sacroiliac joint injections x2, and medications, including Cyclobenzaprine and Gabapentin. The duration of use for current medications could not be determined.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Epidural steroid injection - Lumbar x 3:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of Epidural steroid injections Page(s): 46.

**Decision rationale:** This patient presents with low back pain radiating to the right leg. The current request is for Epidural steroid injection-Lumbar x 3. The RFA is dated 05/29/15. Treatment to date has included diagnostics, physical therapy, and medications. The patient is TTD. The MTUS Chronic Pain Guidelines has the following regarding ESI's Page 46, 47: "Criteria for the use of Epidural steroid injections: 1. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electro diagnostic testing. 3. Injections should be performed using fluoroscopy (live x-ray) for guidance. 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 progress report 05/20/15, the patient presents with of low back pain radiating to the right leg, with numbness and tingling. Objective findings included spasm, decreased range of motion, reduced sensation in the right L5-S1 distribution and straight leg raise test was positive on the right. MRI of the lumbar spine from 06/09/14 revealed 2-3 mm diffuse disc bulge at L4-5. In this case, the patient presents with radicular complaints; however, MRI findings do not suggest radiculopathy. In addition, MTUS does not support a series of three injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections. This request is not medically necessary.

**Trigger point injection - Lumbar x 3:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Trigger point injections.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Trigger Point Injections Page(s): 122.

**Decision rationale:** This patient presents with low back pain radiating to the right leg. The current request is for Trigger point injection - Lumbar x 3. The RFA is dated 05/29/15. Treatment to date has included diagnostics, physical therapy, and medications. The patient is TTD. The MTUS Chronic Pain Guidelines page 122, regarding Trigger Point Injections states that "trigger point injections with a local anesthetic may be recommended for the treatment of chronic low back or neck pain with myofascial pain syndrome when all of the following criteria are met: (1) Documentation of circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain; (2) Symptoms have persisted for more than three months; (3) Medical management therapies such as ongoing stretching exercises, physical therapy, NSAIDs and muscle relaxants have failed to control pain; (4) Radiculopathy is not present (by exam, imaging, or neuro-testing); (5) Not more than 3-4 injections per session; (6) No repeat injections unless a greater than 50% pain relief is obtained for six weeks after an injection and there is documented evidence of functional improvement; (7) Frequency should not be at an interval less than two months; (8) Trigger point injections with any substance (e.g., saline or glucose) other than local anesthetic with or without steroid are not recommended." According to progress report 05/20/15, the patient presents with of low back pain radiating to the right leg, with numbness and tingling. Objective findings included spasm, decreased range

of motion, reduced sensation in the right L5-S1 distribution and straight leg raise test was positive on the right. MRI of the lumbar spine from 06/09/14 revealed diffuse disc bulge of 2-3 mm at L4-5. In this case, there are no documented circumscribed trigger points with evidence upon palpation of a twitch response, as required by MTUS guidelines. Furthermore, the patient presents with radicular pain which is not indicated for TPIs. The request does not meet guideline criteria. The requested trigger point injections are not medically necessary.

### **SI Joint injections x 2: 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)- Sacroiliac blocks.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip and Pelvis Chapter, under SI joint therapeutic injection, Low Back Chapter under SI joint injections.

**Decision rationale:** This patient presents with low back pain radiating to the right leg. The current request is for SI Joint injections x 2. The RFA is dated 05/29/15. Treatment to date has included diagnostics, physical therapy, and medications. The patient is TTD. ODG guidelines, Low Back Chapter under SI joint injections states: "Treatment: There is limited research suggesting therapeutic blocks offer long-term effect. There should be evidence of a trial of aggressive conservative treatment (at least six weeks of a comprehensive exercise program, local icing, mobilization/manipulation and anti-inflammatories) as well as evidence of a clinical picture that is suggestive of sacroiliac injury and/or disease prior to a first SI joint block." ODG further states that, "The history and physical should suggest the diagnosis (with documentation of at least 3 positive exam findings as listed." Diagnosis: Specific tests for motion palpation and pain provocation have been described for SI joint dysfunction: Cranial Shear Test; Extension Test; Flamingo Test; Fortin Finger Test; Gaenslen's Test; Gillet's Test (One Legged-Stork Test); Patrick's Test (FABER); Pelvic Compression Test; Pelvic Distraction Test; Pelvic Rock Test; Resisted Abduction Test (REAB); Sacroiliac Shear Test; Standing Flexion Test; Seated Flexion Test; Thigh Thrust Test (POSH). Criteria for the use of sacroiliac blocks: 7. In the treatment or therapeutic phase (after the stabilization is completed), the suggested frequency for repeat blocks is 2 months or longer between each injection, provided that at least >70% pain relief is obtained for 6 weeks. According to progress report 05/20/15, the patient presents with of low back pain radiating to the right leg, with numbness and tingling. Objective findings included spasm, decreased range of motion, reduced sensation in the right L5-S1 distribution and straight leg raise test was positive on the right. MRI of the lumbar spine from 06/09/14 revealed diffuse disc bulge of 2-3 mm at L4-5. In this case, the treater has not documented more than three positive diagnostic tests to meet SI joint dysfunction criteria as stated above. ODG guidelines require 3 positive exam findings in order to proceed with SI joint injection. In addition, the request is for x2 injections and ODG suggests frequency for repeat blocks to be 2 months or longer between each injection, provided that at least >70% pain relief is obtained for 6 weeks. This request does not meet ODG guidelines criteria; therefore, the request is not medically necessary.

### **Medication Refill: Cyclobenzaprine 10mg #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain).

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

**Decision rationale:** This patient presents with low back pain radiating to the right leg. The current request is for Medication Refill: Cyclobenzaprine 10mg #60. The RFA is dated 05/29/15. Treatment to date has included diagnostics, physical therapy, and medications. The patient is TTD. MTUS Chronic Pain Guidelines pages 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 05/20/15, the patient presents with low back pain radiating to the right leg, with numbness and tingling. Objective findings included spasm, decreased range of motion, reduced sensation in the right L5-S1 distribution and straight leg raise test was positive on the right. The treater has requested a refill of cyclobenzaprine. It is unclear when Cyclobenzaprine was initiated, but it was prior to 05/20/15 as this report requests a refill of medications. MTUS recommends Cyclobenzaprine, only for a short period (no more than 2-3 weeks). The request for #60 does not indicate short-term use of this medication. This request is not in accordance with guidelines. Therefore, the request is not medically necessary.

**Medication Refill: Gabapentin 300mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs (AEDs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin Page(s): 18, 19.

**Decision rationale:** This patient presents with low back pain radiating to the right leg. The current request is for Medication Refill: Gabapentin 300mg #60. The RFA is dated 05/29/15. Treatment to date has included diagnostics, physical therapy, and medications. The patient is TTD. MTUS chronic pain guidelines have the following regarding Gabapentin on pages 18 and 19: "Gabapentin -Neurontin, Gabarone, generic available- has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain." According to progress report 05/20/15, the patient presents with low back pain radiating to the right leg, with numbness and tingling. Objective findings included spasm, decreased range of motion, reduced sensation in the right L5-S1

distribution and straight leg raise test was positive on the right. The treater has requested a refill of Gabapentin. Gabapentin is recommended, per MTUS, as a first-line treatment for neuropathic pain. The patient suffers from radiating pain into the lower extremities, but there is no discussion regarding the effectiveness of Gabapentin. The MTUS guidelines page 60 states, "A record of pain and function with the medication should be recorded," when medications are used for chronic pain. Given this patient has been using this medication chronically, with no documentation of specific efficacy and functional benefit, the request is not medically necessary.