

<b>Case Number:</b>	CM15-0128630		
<b>Date Assigned:</b>	07/15/2015	<b>Date of Injury:</b>	06/03/2013
<b>Decision Date:</b>	08/18/2015	<b>UR Denial Date:</b>	06/18/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/03/2015

### 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 58 year old female with an industrial injury dated 06/03/2013. The injured worker's diagnoses include hypertension and low back pain. Treatment consisted of Magnetic Resonance Imaging (MRI) of lumbar spine, prescribed medications, and periodic follow up visits. In a progress note dated 06/09/2015, the injured worker reported low back pain with radiation down the bilateral lower extremities with associated numbness and tingling. The injured worker rated pain a 0/10 with medications and a 5/10 without medications. Objective findings revealed tenderness to palpitation at L4-S1, limited lumbar range of motion due to pain, decreased sensation in bilateral L4-5 dermatomes and positive straight leg raises on the right. The treating physician prescribed services for lumbar spine epidural injection, Soma 350 mg Quantity: 30 and Voltaren Gel 1%, with 3 refills, now under review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Epidural injection, Lumbar Spine:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): table 12-8. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back - Lumbar epidural steroid injections.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ESI Page(s): 46, 47.

**Decision rationale:** The patient presents with low back pain 5-6/10 intermittent pain radiating to left or right buttock or both and to lateral thigh and tension that radiates to left leg. Muscle spasms in thoracic and lumbar spine randomly occur. Mid back pain 5/10 with stiffness and tightness. The request is for EPIDURAL INJECTION, LUMBAR SPINE. The request for authorization is not provided. MRI of the lumbar spine, 03/18/15, shows mild lower lumbar hyperlordosis without scoliosis; mild multilevel degenerative facet disease throughout the lumbar spine, most pronounced at L4-L5; at L4-L5, there is mild disc space narrowing and disc desiccation in conjunction with a 3-4 mm broad based disc protrusion, mild central stenosis with mild left but more moderate right foraminal narrowing. Physical examination of the lumbar spine reveals muscle guarding. Tenderness to palpation of the paraspinal musculature, spinous process, and piriformis/gluteus groups bilaterally. Range of motion was moderately limited secondary to pain. Sensory exam shows decreased sensitivity touch along the L4-5 dermatomes in both lower extremities. Straight leg raise was positive on the right for radicular pain at 70 degrees. Prior pain treatments include medications, physical therapy and acupuncture. Patient is doing exercises and stretches. She is also exercising 2 times a week in the pool. Patient's medications include Motrin, Soma, Norco and Voltaren Gel. Per progress report dated 06/04/15, the patient is temporarily totally disabled. MTUS page 46, 47 states that an ESI is "Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy)." MTUS further states, "Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 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." Per progress report dated 06/04/15, the treater's reason for the request is "for epidural injection of lumbar spine. Authorized and Scheduled with [REDACTED] on 6/9/15 @ 3:30 PM." Per progress report dated 06/09/15, [REDACTED] states, "The goal of epidural steroid injections is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery." MRI of the lumbar spine, 03/18/15, shows at L4-L5, there is mild disc space narrowing and disc desiccation in conjunction with a 3-4 mm broad based disc protrusion, mild central stenosis with mild left but more moderate right foraminal narrowing. Physical examination reveals straight leg raise was positive on the right for radicular pain at 70 degrees. Sensory exam shows decreased sensitivity touch along the L4-5 dermatomes in both lower extremities. In this case, radiculopathy is documented with dermatomal distribution of pain along with physical examination findings corroborated by MRI findings. Review of medical records show no evidence of a prior Lumbar Epidural Injection. Therefore, the request IS medically necessary.

**Soma 350 mg Qty 30:** Upheld

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

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

**Decision rationale:** The patient presents with low back pain 5-6/10 intermittent pain radiating to left or right buttock or both and to lateral thigh and tension that radiates to left leg. Muscle spasms in thoracic and lumbar spine randomly occur. Mid back pain 5/10 with stiffness and tightness. The request is for SOMA 350 MG QTY 30. The request for authorization is not provided. MRI of the lumbar spine, 03/18/15, shows mild lower lumbar hyperlordosis without scoliosis; mild multilevel degenerative facet disease throughout the lumbar spine, most pronounced at L4-L5; at L4-L5, there is mild disc space narrowing and disc desiccation in conjunction with a 3-4 mm broad based disc protrusion, mild central stenosis with mild left but more moderate right foraminal narrowing. Physical examination of the lumbar spine reveals muscle guarding. Tenderness to palpation of the paraspinal musculature, spinous process, and piriformis/gluteus groups bilaterally. Range of motion was moderately limited secondary to pain. Sensory exam shows decreased sensitivity touch along the L4-5 dermatomes in both lower extremities. Straight leg raise was positive on the right for radicular pain at 70 degrees. Prior pain treatments include medications, physical therapy and acupuncture. Patient is doing exercises and stretches. She is also exercising 2 times a week in the pool. Patient's medications include Motrin, Soma, Norco and Voltaren Gel. Per progress report dated 06/04/15, the patient is temporarily totally disabled. MTUS, Chronic Pain Medication Guidelines, Muscle Relaxants, page 63-66: "Carisoprodol (Soma, Soproval 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. Treater does not specifically discuss this medication. MTUS only recommends short-term use (no more than 2-3 weeks) for sedating muscle relaxants. However, patient has been prescribed Soma since at least 01/29/15. The request for additional Soma #30 does not indicate intended short-term use of this medication. Therefore, the request IS NOT medically necessary.

**Volteran Gel 1%, with 3 refills, unspecified amount:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

**Decision rationale:** The patient presents with low back pain 5-6/10 intermittent pain radiating to left or right buttock or both and to lateral thigh and tension that radiates to left leg. Muscle spasms in thoracic and lumbar spine randomly occur. Mid back pain 5/10 with stiffness and tightness. The request is for VOLTAREN GEL 1%, WITH 3 REFILLS, UNSPECIFIED AMOUNT. The request for authorization is not provided. MRI of the lumbar spine, 03/18/15, shows mild lower lumbar hyperlordosis without scoliosis; mild multilevel degenerative facet disease throughout the lumbar spine, most pronounced at L4-L5; at L4-L5, there is mild disc space narrowing and disc desiccation in conjunction with a 3-4 mm broad based disc protrusion, mild central stenosis with mild left but more moderate right foraminal narrowing. Physical examination of the lumbar spine reveals muscle guarding. Tenderness to palpation of the paraspinal musculature, spinous process, and piriformis/gluteus groups bilaterally. Range of motion was moderately limited secondary to pain. Sensory exam shows decreased sensitivity touch along the L4-5 dermatomes in both lower extremities. Straight leg raise was positive on the right for radicular pain at 70 degrees. Prior pain treatments include medications, physical therapy and acupuncture. Patient is doing exercises and stretches. She is also exercising 2 times a week in

the pool. Patient's medications include Motrin, Soma, Norco and Voltaren Gel. Per progress report dated 06/04/15, the patient is temporarily totally disabled. MTUS has the following regarding topical creams (p111, chronic pain section): "Topical Analgesics: Recommended as an option as indicated below. Non-steroidal anti-inflammatory agents (NSAIDs): The efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period." Treater does not specifically discuss this medication. The patient has been prescribed Voltaren Gel since at least 01/29/15. However, the patient does not present with peripheral joint arthritis/tendinitis, for which an NSAID lotion would be indicated. The request does not meet MTUS indications. Therefore, the request IS NOT medically necessary.