

<b>Case Number:</b>	CM13-0011635		
<b>Date Assigned:</b>	09/23/2013	<b>Date of Injury:</b>	04/12/1991
<b>Decision Date:</b>	01/15/2014	<b>UR Denial Date:</b>	07/26/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/15/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Sports Medicine and is licensed to practice in New York and Texas. 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 physician 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 employee is a 55-year-old female who reported a work-related injury on 04/12/1991 as a result of a fall. Subsequently, the employee presents for treatment of the following diagnoses, postlaminectomy syndrome of the cervical spine, postlaminectomy syndrome of the lumbar spine, compression fracture at L2, fibromyalgia, and degenerative joint disease. The clinical note dated 07/09/2013 reports the employee was seen for follow-up under the care of [REDACTED] for her chronic pain complaints. The provider documents the employee presents with complaints of low back pain, radiation of pain to the bilateral lower extremities, cervical spine pain, shoulder pain, bilateral upper extremity pain, right knee pain, and multiple tender points. The employee reported her pain was at 6/10. The provider documents the employee is status post 2 previous cervical spine surgeries. The employee has undergone 3 previous lumbar spine surgeries, most recent having been performed in 2010. The provider documents the employee reports pain limits in her daily activities. The provider documents since the employee's last visit her pain level has been worse. The employee reports having visited the ER times 2 in the past week due to pain. The employee reports worsening muscle spasms mostly to the cervical spine and the right thigh. The provider documented an imaging study of the employee's lumbar spine revealed a compression fracture at the L2. The employee continues to complain of numbness to the bilateral lower extremities and reduced lower extremity strength and falls. The employee reports numbness to the bilateral upper extremities. The provider documented the employee had undergone lumbar epidural steroid injections in the past and the employee reported relief for several weeks. The provider documents the employee utilizes the following medications, OxyContin 40 mg 1 tab by mouth every 8 hours, Percocet 10/325 mg 1 tab by mouth every 4 to 6 hours, Flexeril 10 mg 1 tab by mouth e

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **One (1) L2 kyphoplasty: 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 (Acute and Chronic).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low back Chapter.

**Decision rationale:** The Official Disability Guidelines indicate, "(1) Presence of unremitting pain and functional deficits due to compression fracture from (a) osteolytic metastasis myeloma hemangioma, (b) osteoporotic compression fracture; (2) Lack of satisfactory improvement with medical treatment such as medications, bracing, and therapy; (3) Absence of alternative of causes for pain such as herniated intervertebral disc by CT or MRI; (4) Affected vertebrae is at least 1/3 of its original height; (5) Fracture age not exceeding 3 months since studies did not evaluate older fractures." According to the medical records provided for review, clinical notes lacked evidence of recent imaging of the employee's lumbar spine to assess the specifics of the L2 disc. Magnetic Resonance Imaging (MRI) from 07/17/2012, does not evidence any significant pathology. There were no more recent imaging studies of the employee's lumbar spine submitted for review to support the requested operative procedure.

### **Flexeril 10mg #90: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril®) Page(s): 41-42.

**Decision rationale:** The Chronic Pain Guidelines indicate, "Flexeril is recommended as an option utilizing a short course of therapy." According to the medical records provided for review, clinical notes evidence the employee has been utilizing this medication in a chronic nature. The clinical notes fail to show evidence that the employee has reported positive efficacy with the current medication regimen as noted by a decrease in rate of pain on a visual analog scale (VAS), and increase in objective functionality.

### **Percocet 10/325 # 180: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, on-going management and Opioids, specific drug list Page(s): 78, 92.

**Decision rationale:** The Chronic Pain Guidelines indicate, "4 domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on Opioids: Pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behavior). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs." The medical records provided for review fail to show evidence of the employee's report of positive efficacy with the current medication regimen as noted by a decrease in rate of pain on a VAS, and increase in objective functionality. The clinical notes lack documentation to support the long-term necessity of this medication for the employee's chronic pain complaints.

**Prozac 20mg # 90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 13-16, 107.

**Decision rationale:** California MTUS Guidelines state SSRIs are not recommended as a treatment for chronic pain, but SSRIs may have a role in treating secondary depression. SSRIs have not been shown to be effective for low back pain. Anti-depressants are recommended as a first-line option for neuropathic pain, and as a possibility for non-neuropathic pain. Tricyclics are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated. As per the clinical notes submitted, the patient has been continuously utilizing this medication. There is no indication that this patient suffers from major depressive symptoms. Additionally, there is no documentation that the ongoing use of this medication has resulted in any changes in the patient's symptoms. Therefore, the continuation of this medication cannot be determined as medically appropriate. Also, there is no evidence of a failure to respond to tricyclic antidepressants prior to the initiation of an SSRI. Based on the clinical information received and the California MTUS Guidelines, the request is non-certified.

**Cervical Epidural steroid injection:** Upheld

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

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

**Decision rationale:** The Chronic Pain Guidelines indicate, "Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing."

The medical records provided for review lacked evidence of a magnetic resonance imaging (MRI) of the cervical spine to support the requested intervention. In addition, the provider documents the employee had utilized previous epidural steroid injections for the pain complaints, and reported positive efficacy for 5 to 6 weeks.

**Lumbar epidural steroid injection:** Upheld

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

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

**Decision rationale:** The Chronic Pain Guidelines indicate, "Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing." According to the medical records provided for review, the employee had utilized previous epidural steroid injections for the pain complaints and reported positive efficacy for 5 to 6 weeks. However, it is unclear when the employee last utilized injection therapy, the objective functional benefits of injection therapy as noted by a decrease in rate of pain on a VAS and increase in functionality. Furthermore, the current request does not specify the levels at which the employee is to receive the epidural steroid injection.

**Unknown Trigger point injection:** Upheld

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

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

**Decision rationale:** The Chronic Pain Guidelines indicate, "No repeat injections unless a greater than 50% pain relief is obtained for 6 weeks after an injection and there is documented evidence of functional improvement." According to the medical records provided for review, the employee had previously utilized trigger point injections for the pain complaints of spasms. The clinical notes do not show evidence of functional improvement status post injections. In addition, the clinical notes do not indicate where the employee is to have the trigger point injections administered.

**Rheumatologist consultation:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (chronic).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92.

**Decision rationale:** The MTUS/ACOEM Guidelines indicate, "Referral may be appropriate if the practitioner is uncomfortable with the line of inquiry outlined above, with treating a particular case of delayed recovery, or has difficulty obtaining information or agreement to a treatment plan." According to the medical records provided for review, the employee was requesting consultation with a rheumatologist; however, a specific rationale by the provider was not evidenced in the clinical notes reviewed.

**Wrist splint:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 264. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 264.

**Decision rationale:** The MTUS/ACOEM Guidelines indicate, "Initial treatment of carpal tunnel syndrome should include night splints, day splints can be considered for employee's comfort as needed to reduce pain along with work modifications." According to the medical records provided for review, the employee had undergone a recent electrodiagnostic study to the bilateral upper extremities; however, the official report of this study was not evidenced in the clinical notes reviewed. Furthermore, the provider failed to document a thorough physical exam of the employee's bilateral wrist to objectively evidence the employee presenting with carpal tunnel syndrome pathology.