

<b>Case Number:</b>	CM13-0033603		
<b>Date Assigned:</b>	01/15/2014	<b>Date of Injury:</b>	07/19/2011
<b>Decision Date:</b>	05/08/2014	<b>UR Denial Date:</b>	09/30/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/10/2013

### 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, has a subspecialty in Interventional Spine 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 patient is a 59-year-old male with a date of injury of 07/19/2011. According to report dated 06/20/2013 by [REDACTED], the patient presents with continued lower back pain with occasional right leg numbness. The patient describes the quality of pain as achy, burning, and numbness. The severity of pain is 7/10. The patient states the problem is relieved with rest and medication. Examination of the lumbar spine revealed there is limited motion of approximately 30 degrees of flexion with spasm. He complains of pain and paresthesias in L4-L5 distribution, right worse than left. There are also symptoms in the sacroiliac regions as well. Reflexes are absent and the motor exam is normal. Report from 05/13/2013 notes, patient does present with some numbness in the right thigh and straight leg raising test is negative bilaterally. The treating physician requests a Flex-Support back brace, series of 3 facet block injections with fluoroscopy, series of 3 epidural injections with fluoroscopy, naproxen 500 mg, Tylenol No. 3, Tramadol 50 mg, Ketorolac 60 mg and physical therapy. [REDACTED] reads the MRI of the lumbar spine dated 02/28/2013 on his progress report from 04/19/2013. The MRI revealed mild disc dissection and facet changes but at no level are the disc protrusions touching any nerve. EMG of the bilateral lower extremities dated 05/24/2012 revealed normal results.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PHYSICAL THERAPY 18 SESSIONS:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**Decision rationale:** The treating physician is requesting 18 physical therapy sessions to help the patient get back to performing normal everyday activities by preserving good range of motion. The treating physician states the physical therapy will help the patient build strength as well as help develop a home exercise program to continue proper body mechanics. For physical medicine, the MTUS Guidelines recommend 9 to 10 visits over 8 weeks for myalgia, myositis, and neuralgia-type symptoms. Review of reports dating from 04/18/2013 to 08/19/2013 does not show that the patient has had any recent course of physical therapy. Although a short course may be indicated for patient's pain and weakness, the requested 18 sessions exceeds what is recommended by MTUS. Recommendation is for denial.

**3 FACET BLOCK INJECTIONS WITH FLUOROSCOPY, LUMBAR SPINE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Facet Joint Diagnostic Blocks.

**Decision rationale:** The treating physician is requesting series of three facet block injections with fluoroscopy to the lumbar spine. ACOEM Guidelines do not support facet joint injections for treatments, but does discuss dorsal medial branch blocks and RF ablations. For a more thorough discussion of facet joint diagnostic evaluation, ODG Guidelines are consulted. ODG Guidelines do support facet diagnostic evaluation for patients presenting with paravertebral tenderness with non-radicular symptoms. However, ACOEM and ODG Guidelines state that therapeutic facet joint injections are not recommended. In this case, the treating physician does not specify diagnostic or therapeutic in which case it is assumed to be therapeutic since he is requesting the injection to provide significant relief and allow the patient palliative treatment. Therapeutic facet injections are not recommended in any of the guidelines. Furthermore, the treating physician states the patient has pain in the spine region as well as radicular symptoms. ODG Guidelines are clear that facet joint injections are for non-radicular symptoms with paravertebral tenderness. The requested 3 facet block injections are not medically necessary and recommendation is for denial.

**TORADOL 60MG INTRAMUSCULAR INJECTION:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Pain Chapter

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 70. Decision based on Non-MTUS Citation Academic Emergency Medicine, Volume V, pages 118-122

**Decision rationale:** The treating physician is requesting a Toradol 60 mg IM injection. The MTUS Guidelines state that NSAIDs are recommended with cautions below: Disease-state warnings for all NSAIDs, all NSAIDs have US boxed warnings for associated risk of adverse cardiovascular events including MI, stroke, and new onset or worsening of pre-existing hypertension. Boxed warning for ketorolac 10 mg states that medication is not indicated for minor or chronic painful conditions." Furthermore, the Academic Emergency Medicine volume V page 118 to 122 states that intramuscular ketorolac versus oral ibuprofen in patients showed no difference between the two and both provided comparable levels of analgesia in emergency patients presenting with moderate to severe pain. The requested Toradol intramuscular injection is not medically necessary and recommendation is for denial.

**TRAMADOL 50MG #180:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 88-89.

**Decision rationale:** The treating physician is requesting a refill of Tramadol 50mg. For chronic opiate use, the MTUS Guidelines require functioning documentation using a numerical scale or a validated instrument at least once every six months. Documentation of the 4A's (analgesia, ADLs, adverse side effects, and adverse behavior) is required. Furthermore under outcome measures, MTUS states that measures of pain assessment that allow for evaluation of the efficacy of opioids and whether their use should be maintained include the following: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Medical records document the patient was prescribed Tramadol 100mg by [REDACTED] on 04/19/2013, as NSAIDs were not adequately controlling his pain. On 06/24/2013, [REDACTED] recommended that the patient continue with Tramadol. In this case, the treating physician does not provide any discussions regarding pain relief or functional improvement from using Tramadol. There is no significant change in ADLs, change in work status, or return to work attributed to the use of this medication. Given the lack of sufficient documentation demonstrating efficacy from chronic opiate use, the patient should now slowly be weaned as outlined in MTUS Guidelines. Recommendation is for denial.

**4-LEAD TENS UNIT:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS  
Page(s): 116.

**Decision rationale:** The treating physician is requesting a TENS unit to relieve pain. Per MTUS Guidelines, TENS units have not proven efficacy in treating chronic pain and are not recommended as a primary treatment modality, but a 1-month home-based trial may be considered for specific diagnoses of neuropathy, CRPS, spasticity, and phantom limb pain and multiple sclerosis. In this case, recommendation is for denial as this patient does not present with any of the diagnoses that MTUS allows for the trial of a TENS unit. Furthermore, when TENS unit is indicated, a trial of 30 days is recommended. The treating physician failed to specify the duration of use. Recommendation is for denial.

**LUMBAR SPINE FLEX SUPPORT BACK BRACE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.  
Decision based on Non-MTUS Citation ODG, Low Back, Lumbar Supports.

**Decision rationale:** The ACOEM Guidelines state that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. ODG Guidelines regarding lumbar supports states that they are not recommended for prevention, however, recommended as an option for compression fractures and specific treatment of spondyloisthesis, documented instability, and for treatment of nonspecific lower back pain (very low quality evidence but may be a conservative option). In this case, the patient does not present with fracture, instability or spondyloisthesis to warrant lumbar bracing. The patient does have non-specific low back pain but this has very low-quality evidence of efficacy. Given the lack of support from the guidelines, recommendation is for denial.

**SERIES OF THREE EPIDURAL STEROID INJECTIONS (ESI) WITH  
FLUOROSCOPY FOR THE LUMBAR SPINE:** Upheld

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

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

**Decision rationale:** The MTUS Guidelines states that ESIs are recommended as an option for treatment of radicular pain. It goes on to state that current research does not support series of 3 injections in either the diagnostic or therapeutic phase. No more than 2 ESI injections are recommended. In this case, a review of reports from 04/19/2013, 05/13/2013 and 06/24/2013, do not indicate that this patient presents with any radicular symptoms. There is subjective complaint of pain and paresthesias in L4-L5 distribution. However, there are no positive findings on examination. The MRI from 02/28/2013 does not show significant stenosis or herniation. ESI's

are not recommended unless the patient has radicular symptoms that are corroborated by imaging studies. Furthermore, MTUS does not support series of 3 injections. Recommendation is for denial.