

<b>Case Number:</b>	CM13-0054445		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	03/21/2009
<b>Decision Date:</b>	03/17/2014	<b>UR Denial Date:</b>	10/18/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/19/2013

### 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 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 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 patient is a 48-year-old female with date of injury of 03/21/2009. Per treating physician's report on 09/20/2013, the patient presents with ongoing pain complaints, had an injection in the left shoulder without complications, current complaints include low back pain at an intensity of 8/10 to 9/10 extending to the left leg and foot, neck pain at 7/10 to 8/10 with bilateral upper extremity radiation, left shoulder and chest pain as well. Objective findings showed limited range of motion of cervical, thoracic, and lumbar spine, decreased sensation left C5 to C7 dermatomes, left L4-L5 dermatomes, 4+/5 left deltoid to biceps internal/external rotators, wrist extensors/flexors, 5-/5 on the right side in the upper extremity. Motor examination showed 4+/5 tibialis anterior, 4/5 left EHL, 4+/5 right EHL, 4+/5 bilateral inversion, plantarflexion, and eversion. The treating physician's listed diagnoses were: 1. Left shoulder subacromial impingement. 2. Cervical radiculopathy. 3. Lumbar radiculopathy. 4. Left shoulder SLAP lesion. 5. Cystic change/edema in the triquetrum and capitate. 6. Cervical degenerative disk disorder with stenosis. 7. Lumbar degenerative disk disorder with facet arthropathy. 8. Moderate canal stenosis of the lumbar spine. Request for authorization was prolonged by epidural steroid injection of left L4-L5, interlaminar at C5-C6, ongoing orthopedic followups with [REDACTED], CT scan of the chest as recommended by [REDACTED], 6 sessions of hand therapy, physical therapy for cervical and lumbar spine for 12 sessions, and Norco, Flexeril, Promolaxin and Terocin cream. Their treating physician is also recommending mesh pack support. MRI of the lumbar spine from 08/16/2013 showed retrolisthesis with degeneration at L4-L5, moderate spinal stenosis at L4-L5, L5-S1 with some foraminal stenosis at L2-L3, L3-L4, and L4-L5 levels particularly moderate on the left side at L4-L5.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Interlaminar epidural steroid injections C5-C6: 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 Section Epidural Steroid Injections (ESIs).

**Decision rationale:** This employee presents with chronic neck and upper extremity pain. The treating physician has asked for interlaminar epidural steroid injection and review of the report shows that this has been requested all throughout 2013. MTUS Guidelines page 46 and 47 recommend ESI for treatment of radicular pain defined as pain in a dermatomal distribution with corroborative findings of radiculopathy. They further indicate that radiculopathy must be documented by physical examination and imaging study/electrodiagnostic testing. In this employee, despite review of 249 pages of reports, no MRI of the cervical spine was submitted. However, panel QME physician makes reference to MRI from June 2011 that showed only degenerative disk changes. The panel QME report is from 04/03/2013. The treating physician does not describe any MRI findings. The pain is described as bilateral upper extremity pains and is not described in dermatomal distribution. The examination showed decreased sensation in multiple levels of the left side at C5 through C8. Diagnosis described as only degenerative disc disease with cervical stenosis. In this case, there is no corroboration between the employee's presenting symptoms. There is lack of dermatomal distribution to pain that would suggest a clear diagnosis of radiculopathy. There is no description of MRI findings and the only description I found was that of June 2011 that showed degenerative disc changes. Physical examinations do not identify specific levels other than showing diffuse sensory changes from C4 to C7. EMG/NCV studies of upper extremity from 08/13/2013 apparently showed chronic C5 radiculopathies, but that report was not available for review and there are no corroborating findings on imaging studies to verify C5 nerve root issues. Given the lack of these findings, recommendation is for denial.

### **Transforaminal lumbar epidural steroid injection Left L4-L5 roots: Overturned**

**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 Section Epidural Steroid Injections (ESIs).

**Decision rationale:** This employee presents with chronic low back and radiating symptoms down the left lower extremity. The request is for left L4-L5 transforaminal epidural steroid injection. In this employee, the treating physician does describe radiating symptoms down the left lower extremity, examination shows more weakness on the left lower extremity than the right side for left extensor hallucis longus and tibialis anterior. MRI of the lumbar spine

showed significant left-sided foraminal stenosis at L4-L5 due to retrolisthesis at L4-L5. The employee is presenting symptoms of the left lower extremity, physical examination findings with some weakness in the left lower extremity and MRI showing foraminal stenosis at L4-L5 to corroborate for a diagnosis for radiculopathy. MTUS Guidelines support ESI as an option for radiculopathy. In this employee, despite review of all the reports of 2013 and before, I do not see that the employee has had an epidural steroid injection from the past. Recommendation is for authorization.

**Physiotherapy of the cervical and lumbar spines 12 sessions:** 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 Section Physical Medicine Page(s): 98-99.

**Decision rationale:** This employee presents with chronic neck and low back symptoms with MRI of the C-spine showing degenerative disc changes only from June 2011; MRI of the lumbar spine from December 2011 showing retrolisthesis at L4-L5 with degenerative disc changes. Despite review of 249 pages, I was not able to tell that the employee recently had a course of physical therapy. The MTUS Guidelines do support physical therapy but for number of treatments, it recommends 9 to 10 sessions for myalgia, myositis, neuritis, radiculitis type of problems. In this case, the request exceeds what is allowed by MTUS and therefore, recommendation is for denial.

**CT scan of the chest:**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

**Decision rationale:** Despite review of entire progress reports from 2013, I was not able to find the treating physician's report that he is actually recommending CT scan of the chest referred by another treating physician in his numerous reports from 2013. There were reports from the first treating physician on 03/26/2013 and 01/03/2013. Neither of these reports requested CT scan of the chest. In reference to chest pain, another physician's report from 08/07/2013 describes epigastric pain with burning sensation about 3 times a week. However, the same physician reports that omeprazole helps, which the employee takes 2 to 3 times a week. There was no bleeding, melena, or hematochezia. Diagnosis was that of gastropathy, resolved. Recommendation was for continued use of Prilosec. The second treating physician has asked for a CT scan but I was not able to determine the rationale behind the CT scan other than the reference to epigastric pain and discomfort, which is well controlled with Prilosec. Furthermore, the first treating physician, in his reports on 03/26/2013, 01/03/2013, make reference to AME evaluations that do not recommend CT scan of the chest. In reference to CT

scans for thoracic and cervical spine, the indications are for trauma or suspected trauma. In this case, the treating physician does not provide any rationale for the request of the CT scan. Recommendation is for denial.

**Six (6) sessions of hand therapy:**

**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 Section Physical Medicine Page(s): 98-99.

**Decision rationale:** This employee presents with symptoms in the neck, shoulder, upper extremity, low back, and lower extremity. The treating physician has asked for hand therapy 6 sessions. However, none of the reports described any hand symptoms. Electrodiagnostic studies of the upper extremities from 08/13/2013 showed chronic C5 radiculopathies but no carpal tunnel syndrome, ulnar neuropathies, or other symptoms that may affect the patient's bilateral hands. There were no osteoarthritis or other problems described other than "cystic change/edema in the triquetrum and capitate" per the treating physician's diagnosis. Again, the treating physician requests 6 sessions of hand therapy referencing another treating physician, but that physician's reports from 03/26/2013, 01/03/2013 do not have discussion regarding hand therapy. The MTUS Guidelines allow for 9 to 10 sessions of physical therapy for myositis, myalgia, neuritis, radiculitis type of symptoms. In this case, the treating physician does not describe any specific hand symptoms, although the employee has had chronic neck and upper extremity pains. Recommendation is for denial.

**Cyclobenzaprine 7.5 mg, #60: 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 Section Muscle Relaxants Page(s): 63-64.

**Decision rationale:** This employee presents with chronic pain in neck and low back with radiation into the upper and lower extremities. The treating physician has been consistently prescribing cyclobenzaprine for the employee's spasms stating that this medication helps. The MTUS Guidelines specifically do not recommend long term use of muscle relaxants such as cyclobenzaprine. If it is to be used, the recommended use is for less than 2 to 3 weeks. In this employee, this medication has been prescribed on a long term basis and recommendation is for denial.

**Hydrocodone 5/325 mg, #45: 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 Section Long-term Opioid Use Page(s): 88-89.

**Decision rationale:** This employee presents with chronic pains to the neck and low back and upper and lower extremity pains. The treating physician has been prescribing hydrocodone for number of months throughout year 2013. The MTUS Guidelines indicate on page 88 and 89 for long term users of opioids 6 months or more, documentation of pain and functional improvement and comparison to baseline is required. Functioning should be assessed via numerical scale or validated instrument at least once every 6 months. In this employee, I reviewed the reports from 01/18/2013 to 09/30/2013. The treating physician has provided generic descriptions of benefit from the medication use such as decreased pain, increased function, walking, cooking, and cleaning per September 2013 report, but no specifics are provided and no numerical scales are provided before and after medication use. Furthermore, the treating physician provides conflicting reports. On one hand, medications are increasing function such walking, cooking, and cleaning. On the other hand, the employee's pain level has gradually increased from 7/10 to 8/10 on 02/15/2013 report to 9/10 consistently towards 10/13/2013 and 09/20/2013. Report on 08/23/2013 also states that "pain complaints that are largely unchanged" with employee having difficulties with activities. Most importantly, review of the 2013 reports show gradual increase in the employee's pain with many of the reports stating that the employee's pain is increasing with functional decline. One cannot tell that Norco has done anything for this employee based on the review of the reports. Given the lack of documentation of pain improvement, no documentation of numerical scales showing functional difference, no outcome measures as defined by the MTUS Guidelines, continued use of Norco is not recommended. Recommendation is for denial.

**Terocin Pain Patch 10 patches #1:** 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 Section Topical Analgesics Page(s): 111.

**Decision rationale:** This employee presents with some chronic neck and low back pains with radiating symptoms of the upper and lower extremities. The treating physician has prescribed Terocin patch/cream indicating that this helps with pain, increases function, and decreases the employee's need for other medications. It is difficult to tell what he is exactly prescribing as under treatment plan, he makes reference to "Terocin cream" but on the request for authorization, he has asked for Terocin pain patch, 10 patches. Terocin patch contains 4% lidocaine with menthol. The MTUS Guidelines under topical analgesic page 111 provides discussion regarding topical lidocaine. It states that it is recommended for localized peripheral pain of neuropathic origin. In this employee, there is no localized peripheral pain as this employee suffers from chronic neck, low back with radiating symptoms to the upper and lower extremities. The treating physician does not specify where the patches are precisely used. It is assumed that the employee is using them for neck and low back symptoms. However, the lidocaine patches

are not indicated for musculoskeletal pain or the spine, but they are indicated for neuropathic localized peripheral pain. Diffuse radiating symptoms of the upper and lower extremities are not localized peripheral pain. Recommendation is for denial.

**Mesh Back Support:** Overturned

**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): 308. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Section Guidelines for Lumbar Supports

**Decision rationale:** This employee presents with chronic low back pain with MRI demonstrating retrolisthesis at L4-L5, left-sided foraminal stenosis at L4-L5 and moderate spinal stenosis at L4-L5 and L5-S1. The treating physician has prescribed mesh back support for the lumbar spine. ACOEM Guidelines page 301 indicate lumbar supports had not been shown to have any lasting benefit beyond the acute phase of symptom relief. The ODG Guidelines provided more detailed discussion regarding the use of lumbar supports. Lumbar supports are not recommended for prevention and for treatments. It is recommended as an option for compression fracture, specific treatments of spondylolisthesis, documented instability, and for treatment of nonspecific low back pain. However, for nonspecific low back pain, the ODG Guidelines indicate very low quality evidence, but may be a considerable option. Recommendation is for authorization as the ODG Guidelines support this for treatment of nonspecific low back pain and considers it a conservative option.