

<b>Case Number:</b>	CM14-0007638		
<b>Date Assigned:</b>	02/07/2014	<b>Date of Injury:</b>	04/14/2008
<b>Decision Date:</b>	08/07/2014	<b>UR Denial Date:</b>	01/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/16/2014

### 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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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 60-year-old female who has submitted a claim for status post anterior cervical discectomy and fusion C3-7, right shoulder impingement syndrome, L4-5 disc herniation with bilateral lower lumbar radiculopathy, and upper extremity overuse tendinopathy associated with an industrial injury date of 06/09/2005. Medical records from 07/28/2009 to 03/06/2014 were reviewed and showed that patient complained of ongoing neck and right shoulder pain graded 6/10 with associated numbness in both hands. There was complaint of stabbing back pain graded 7/10 with tingling sensation in both hands. Physical examination of the cervical spine revealed a well-healed incision in the anterior neck. Tenderness over the cervical paraspinous muscles was noted. Cervical ROM was decreased. MMT, DTR, and sensation to light touch of bilateral upper extremities were normal. Physical examination of the right shoulder revealed tenderness over the anterior capsule, sternoclavicular joint, and acromioclavicular joint. Right shoulder ROM was decreased with crepitus upon movement. Neer's and Hawkin's test were positive. O'brien's test, apprehension test, and drop arm sign were negative. Physical examination of the lumbar spine revealed tenderness and spasm over the lumbar paraspinous muscles. Lumbar ROM was decreased. MMT of bilateral lower extremities was intact except for plantar flexors and dorsiflexors (both 4/5). Sensation to light touch of bilateral lower extremities was intact except in the foot dorsum and posterolateral calf. SLR test in the supine and seated position was positive bilaterally at 60 and 50 degrees, respectively. MRI of the right shoulder dated 08/16/2012 revealed fluid in the subacromial-subdeltoid bursa. MRI of the cervical spine dated 07/28/2009 revealed C3-7 mild disc desiccation and protrusion and C5-6 foraminal stenosis. Treatment to date has included anterior cervical discectomy and fusion C3-7 (04/18/2012), acupuncture, physical therapy, TENS, chiropractic treatment, home exercise programs, intramuscular injections, pain medications, patches, and creams. Utilization review

dated 01/03/2014 denied the request for intramuscular injection of 80mg of Depo Medrol and 80 mg of Kenalog because it was not medically indicated based on the clinical findings and guidelines. Utilization review dated 01/03/2014 denied the request for intramuscular injection of toradol because guidelines state that Toradol is not indicated for management of chronic pain.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **RETROSPECTIVE REQUEST FOR 1 INTRAMUSCULAR INJECTION OF 80 MG DEPO MEDROL AND 80 MG OF KENALOG: 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-Lumbar and Thoracic (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, Corticosteroid Injections.

**Decision rationale:** CA MTUS does not address the topic on corticosteroid injections. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Divisions of Workers Compensation, Official Disability Guidelines was used instead. ODG recommends corticosteroid injection such as depo medrol in limited circumstances for acute radicular pain. Patients should be aware that research provides limited evidence of effect with this medication. Corticosteroid injection is not recommended for acute non-radicular pain (i.e. axial pain) or chronic pain. Overall it is suggested that the main effect of systemic steroids is to provide pain relief (which is reported as minimal in current research) in the early acute period. The criteria for the use of corticosteroid injections include clear-cut signs and symptoms of radiculopathy and chronic phase of injury treatment should generally be after a symptom-free period with subsequent exacerbation or evidence of a new injury. In this case, the patient has been administered with three intramuscular injections of Depo Medrol 80mg and Kenalog (2012, 12/06/2013, and 03/06/2014). However, it was documented that the patient had recurrent pain a week after receiving intramuscular injections (11/1/2013, 11/30/2012). Moreover, the patient does not fit in the aforementioned criteria. The patient's injuries were chronic and there was no objective evidence of acute exacerbation. Therefore, the request for retrospective request for 1 intramuscular injection of 80 mg Depo Medrol and 80 mg of Kenalog is not medically necessary.

#### **RETROSPECTIVE REQUEST FOR 1 INTRAMUSCULAR INJECTION OF 2 CC TORADOL: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines (MAY 2009), NSAIDs, SPECIFIC DRUG LIST & ADVERSE EFFECTS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) PAIN, (CHRONIC).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 72. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, NSAIDS Specific Drug list & Adverse Effects.

**Decision rationale:** According to CA MTUS Chronic Pain Treatment Guidelines, Ketorolac (Toradol, generic available) 10 mg is not indicated for minor or chronic painful conditions. According to ODG pain Chapter, ketorolac [Boxed Warning] may be used as an alternative to opioid therapy when administered intramuscularly. The FDA boxed warning would relegate this drug to second-line use unless there were no safer alternatives. In this case, the patient has been administered with three intramuscular injections of toradol (2012, 12/06/2013, and 03/06/2014). However, it was documented that the patient had recurrent pain a week after receiving intramuscular injections (11/1/2013, 11/30/2012). Moreover, the administration of Toradol intramuscularly will not be in conjunction with guidelines recommendation. It is unclear as to why Toradol is requested despite potential adverse effects. The specific date to consider, as this is a retrospective request is likewise not indicated. Therefore, the retrospective request for 1 intramuscular injection of 2 cc Toradol is not medically necessary.