MAXIMUS Federal Services

| Case Number: | CM14-0162444 | | |
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| Date Assigned: | 10/07/2014 | Date of Injury: | 12/06/2011 |
| Decision Date: | 11/10/2014 | UR Denial Date: | 09/15/2014 |
| Priority: | Standard | Application Received: | 10/02/2014 |

## 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 Orthopaedic Surgery 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:

This 75-year-old female sustained an industrial injury on 12/6/11, relative to a fall. Past surgical history was positive for left gastrocnemius slide procedure, debridement of the left Achilles tendon, and repair of the left Achilles insertional tear on 7/11/13, and right shoulder arthroscopy with acromioplasty and rotator cuff repair on 4/21/14. The 8/4/14 lumbar spine MRI impression documented moderately severe central stenosis at L3/4 and L4/5 due primarily to degenerative facet disease and facet hypertrophy. There was degenerative facet disease at L5/S1 with grade 1 spondylolisthesis with no significant central or foraminal stenosis. The 8/4/14 right hip MRI impression documented a small tear at the base of the right anterior labrum, and tendinosis of the gluteus medius and minimus muscles. The 8/7/14/14 treating physician report cited complaints of neck, right shoulder, low back, right hip and right foot pain. She reported increased low back and right hip pain that had only mildly reduced with ice and stretching. She was requiring additional Norco for pain. She was having difficulty tolerating the pain and trouble with mobility. She was working full time but struggling to complete her day. Medications allowed her to work and reduced the pain to tolerable levels. Pain levels without medication were 9/10 and with medications was 2/10. A TENS unit was also helping with decreased muscle tightness and pain relief. She was doing well status post right shoulder surgery with minimal pain. Right foot surgery was pending. Physical exam documented antalgic gait, with a walking boot but no assistive devices. Lumbar spine exam documented increased lumbar lordosis, anterior pelvic tilt, lumbosacral paraspinal muscle tightness, and sacroiliac joint and sciatic notch pain to palpation. There was mild to moderate limitation in lumbar range of motion. There was 5/5 strength, intact sensation, +2 patellar reflexes and +1 Achilles reflexes bilaterally. Patrick's sign and Gaenslen's maneuver were positive bilaterally. There was right hip pain with palpation and decreased range of motion in all planes. The overall impression was chronic low back pain with lumbar

spondylosis and MRI evidence of severe L3/4 to L5/S1 facet arthropathy with multilevel degenerative disc disease. There was lower extremity radiculitis without electrodiagnostic evidence of lumbosacral radiculopathy or peripheral neuropathy. The treatment plan requested authorization for bilateral L3/4 and L4/5 facet injections for pain reduction and improved function, as well as diagnostic to assess the facet joints as pain generators. The patient would be referred to an orthopedic surgeon for consultation of her right hip based on MRI results. Continued medications were requested including cyclobenzaprine, Tramadol ER, Voltaren XR, trazodone, and Norco. The 9/15/14 utilization review modified the request for lumbar facet steroid injections at bilateral L3-4 and L4-5 under fluoroscopic guidance and with conscious sedation. The bilateral L3/4 and L45 lumbar facet steroid injections were approved without conscious sedation as this request was for diagnostic injections and the use of conscious sedation would be grounds to negate the diagnostic implications of the procedure. The request for a one-time consultation with an orthopedic surgeon for the right hip was denied as there was no evidence that the patient had failed conservative treatment to warrant specialty evaluation at this time. Flexeril was denied as the patient had been on this medication for at least several months in excess of guideline recommendations and there was no documentation of any clinical efficacy. Desyrel (trazodone) was denied as the patient reported that this medication was no longer helping her insomnia. The continued use of Voltaren was denied as the patient was recently found to have elevated liver enzymes and there were increased hepatic risks associated with the medication.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Lumbar facet steroid injection bilateral L3-4 and L4-5 under fluoroscopic guidance and with conscious sedation:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 300-301. Decision based on Non-MTUS Citation ODG-TWC, Low Back Chapter

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 187-190. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic, Facet joint diagnostic blocks (injections)

**Decision rationale:** The California MTUS guidelines state that therapeutic facet joint injections are not recommended for acute, subacute, chronic lower back pain or for any radicular pain syndrome. One diagnostic facet joint injection may be recommended for patients with chronic lower back pain that is significantly exacerbated by extension and rotation, or associated with lumbar rigidity, and not alleviated with other conservative treatments, in order to determine whether specific interventions targeting the facet joint are recommended. Clinical presentation should be consistent with facet joint pain, signs and symptoms. The Official Disability Guidelines support facet diagnostic injections limited to patients with non-radicular low back pain at no more than two levels. There should be documentation of failure of conservative treatment, including home exercise, physical therapy, and anti-inflammatory medications. The 9/15/14 utilization review modified the request for lumbar facet steroid injections at bilateral L3-4 and L4-5 under fluoroscopic guidance and with conscious sedation. The bilateral L3/4 and L45

lumbar facet steroid injections were approved without conscious sedation to allow for diagnostic feedback. There is no compelling reason to support the medical necessity beyond treatment already certified. Therefore, this request is not medically necessary.

**One time consultation with an orthopedic surgeon for right hip:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM guidelines page 127

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Independent Medical Examinations and Consultations Page(s): 127.

**Decision rationale:** The California MTUS guidelines support referral to a specialist if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. Guideline criteria have been met in this case. The patient presents with right hip pain and imaging findings of a small labral tear. It is reasonable for an orthopedic consult to assist in development of a treatment pain. Therefore, this request is medically necessary.

**Flexeriol 7.5mg, 1/2- 1 a bedtime as needed for muscle spasm, #60 (prescribed 9-5-14):** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril), Muscle relaxants (for pain) Page(s): 41-42, 63-65.

**Decision rationale:** The California MTUS guidelines recommend the use of cyclobenzaprine (Flexeril) as an option, using a short course of therapy, in the management of back pain. Treatment should be brief. This medication is not recommended to be used for longer than 2 to 3 weeks. Guideline criteria have not been met for continued use. Records indicate that this medication has been prescribed since at least 4/3/14. There is no documentation of specific functional benefit associated with the patient's use of this medication. Given the absence of guideline support beyond 2 to 3 weeks, discontinuation is indicated. Therefore, this request is not medically necessary.

**Desyrel150mg, #60 (prescribed 9/5/14):** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) PAIN (CHRONIC) INSOMNIA TREATMENT

**Decision rationale:** The California MTUS guidelines do not make recommendations relative to this medication. The Official Disability Guidelines indicate that sedating antidepressants, such as Desyrel (Trazodone), may be used to treat insomnia as an option in patients with co-existing depression. Guidelines recommend that insomnia treatment be based on the etiology. Pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. Failure of sleep disturbance to resolve in a 7 to 10 day period may indicate a psychiatric and/or medical illness. Guideline criteria have not been met for continued use. The patient is reporting that this medication is no longer working. Given the absence of documented benefit, this request is not medically necessary.

**Voltaren XR 100mg, 1 by mouth daily for pain and inflammation, #30 (prescribed 9/5/14):** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS (NON-STEROIDAL ANTI-INFLAMMATORY DRUGS) Page(s): 67-72.

**Decision rationale:** The California Medical Treatment Utilization Schedule (MTUS) guidelines state non-steroidal anti-inflammatory drugs (NSAID), such as Voltaren, are indicated for short term lowest dosage treatment of symptoms associated with osteoarthritis and chronic back pain and as a second line option for acute exacerbations of chronic back pain. NSAIDs are recommended at the lowest dose for the shortest period of time for patients with moderate to severe pain from osteoarthritis. Guidelines warm that NSAIDs may elevate liver enzymes in 15% of patients. Guideline criteria have not been met. This patient has been using this medication since at least 4/13/14 with no documentation of a specific pain reduction or function benefit. Records indicate that the patient has elevated liver enzymes. Given the recommendation for short term use and absence of documented clinical efficacy, continuation of this medication is not supported. Therefore, this request is not medically necessary.