

<b>Case Number:</b>	CM14-0181355		
<b>Date Assigned:</b>	11/06/2014	<b>Date of Injury:</b>	09/06/2004
<b>Decision Date:</b>	12/11/2014	<b>UR Denial Date:</b>	10/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/03/2014

### 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 Family Medicine 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 is a 55-year-old female patient who reported an industrial injury on 9/6/2004, over ten years ago, attributed to the performance of her usual and customary job tasks reported as moving a container of water. The patient complained of persistent lower back pain. The patient did more cleaning than usual, which resulted in increased pain levels. The patient has an SCS implanted to help manage lower extremity pain. The CT scan of the lumbar spine was reported to demonstrate facet arthropathy as a potential source of lower back pain. The diagnoses included lumbar degenerative disc disease with intractable low back pain; bilateral lower extremity radiculopathy left greater than right; facet arthropathy; mechanical back pain; depression secondary chronic pain; insomnia secondary to pain; obesity and situational stress. The treatment plan included Toradol IM injections of one per month for the next 12 months; refill Percocet; refill Flexeril; refill Voltaren gel; physical therapy 28 as a patient was deconditioned; and facet injections bilaterally at L3, L4-L5, L5, and S1. The patient was noted to have a prior radiofrequency ablation at L3-L4 and L4-L5 and L5-S1 on 12/30/2013, which resulted in no functional improvement. It is noted that the patient had completed 84 sessions of physical therapy to date.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Facet joint injection, levels L3-3, L4-4, L5-S1, bilateral:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 300 and 309;174-75;174;187,Chronic Pain Treatment Guidelines injections Page(s): 54. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back chapter--Facet joint blocks and injections; MBB

**Decision rationale:** The patient was noted to have received prior RFA treatment with no functional improvement. The patient has a SCS for the management of pain. The request for the MMB or facet blocks to lumbar spine at bilateral L3-4; L4-L5; and L5-S1 is inconsistent with the recommendations of the ACOEM Guidelines or the ODG for the treatment of this injured worker. The request for a MMB or facet blocks to lumbar spine bilateral L3-4; L4-L5; and L5-S1 was ordered in order to provide relief from the reported symptoms instead of for diagnostic purposes. The CA MTUS is silent on the use of facet blocks. There is no objective evidence of facet arthropathy to the lumbar spine based on a MRI. There is no pain documented with extension and rotation. There is no evidence that facet arthropathy is the pain generator for the reported chronic low back pain. There are no documented neurological deficits. The patient had a prior radiofrequency ablation. There are no demonstrated medical necessity median branch blocks to the lumbar spine for the cited diagnoses. There was no demonstrated rationale to support the medical necessity of the requested medial branch blocks or facet blocks for the diagnosis of chronic low back pain. The use of facet blocks and RFA to the lumbar spine is not recommended by the CA MTUS. The ACOEM Guidelines state that facet blocks are of "questionable merit." The CA MTUS states that facet blocks are "limited to patients with lumbar pain that is non-radicular and at no more than two levels bilaterally." The patient is diagnosed with back pain and the evaluation of this pain generator should occur prior to the evaluation and treatment of assessed facet pain. The request for the authorization of diagnostic/therapeutic facet blocks or median branch blocks for chronic lumbar spine pain is inconsistent with the recommendations of the CA MTUS, the ACOEM Guidelines, and the Official Disability Guidelines. The recommendations are for the provision of facet blocks is not recommended. There is no provided objective evidence that the axial lumbar pain or degenerative disc disease is influenced by additional pain generated from facet arthropathy. The ACOEM Guidelines revised 4/07/08 for the lower back recommend: "One diagnostic facet joint injection may be recommended for patients with chronic LBP that is significantly exacerbated by extension and rotation or associated with lumbar rigidity and not alleviated with other conservative treatments." There is no demonstrated medical necessity for the requested MMB or facet blocks to lumbar spine bilateral L3-4; L4-L5; and L5-S1.

**Toradol 60mg IM times twelve (120): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-06,Chronic Pain Treatment Guidelines anti-inflammatory medications Page(s): 22; 67-68. Decision based on Non-MTUS Citation American College of Occupational and

Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 6 pages 114-16 Official Disability Guidelines (ODG) Pain chapter--NSAIDs; Ketorolac--Toradol

**Decision rationale:** The request for monthly IM injection of Toradol for pain was reportedly to give pain relief; however, the patient was previously prescribed a significant polypharmacy of oral and topical medications. The patient is prescribed Percocet concurrently. The patient is 10 years s/p DOI and there is no medical necessity for the provision of IM Toradol in the office setting in addition to the prescribed medications. There is no demonstrated medical necessity for the IM injection of a NSAID in addition to the prescribed analgesics. The patient should be taking oral NSAIDs and there is no medical necessity for an IM injection of an NSAID for the reported flare up or on a routine monthly bases reportedly to help pain control. The provision of Toradol IM was directed to chronic back pain in addition to the prescribed polypharmacy. There is no medical necessity for the provision of IM Toradol in the outpatient treatment setting for the cited diagnosis of chronic low back pain. There is no demonstrated medical necessity for the IM delivery of NSAIDs versus the oral route for the treatment of this patient. The patient was treated for chronic pain issues and the office setting injection was inconsistent with the recommendations of the ODG. There is no evidence that the IM NSAIDs are more effective than PO NSAIDs. There is no demonstrated medical necessity for the provision of Toradol IM 60 mg on a routine monthly basis for twelve (12) months.

**Physical therapy; sixteen (16) sessions (2x8): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299-300, Chronic Pain Treatment Guidelines physical medicine Page(s): 97-98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) neck and upper back chapter-PT; back chapter-PT

**Decision rationale:** The request is for authorization of 2x8 additional sessions of PT to the back 10 years after the DOI exceeds the number of sessions of PT recommended by the CA MTUS and the time period recommended for rehabilitation. The patient is documented to have received 84 sessions of PT for the effects of this industrial claim. The evaluation of the patient documented no objective findings on examination to support the medical necessity of additional physical therapy over the recommended self-directed home exercise program with documented weakness but no muscle atrophy as opposed to a self-directed HEP. There are no objective findings to support the medical necessity of 18 additional sessions of physical therapy for the rehabilitation of the patient over the number recommended by evidence-based guidelines. The patient is noted to be status post 84 sessions of rehabilitation physical therapy. The patient is documented with no signs of significant weakness, no significant reduction of ROM, or muscle atrophy. There is no demonstrated medical necessity for the prescribed PT to the back 10 years after the DOI. The patient is not documented to be in HEP. There is no objective evidence provided by the provider to support the medical necessity of the requested 18 additional sessions of PT over a self-directed home exercise program. The CA MTUS recommends ten (10) sessions of physical therapy over 8 weeks for the lumbar spine rehabilitation subsequent to

lumbar/thoracic strain/sprain and lumbar spine DDD with integration into HEP. The provider did not provide any current objective findings to support the medical necessity of additional PT beyond the number recommended by evidence-based guidelines. The request for an additional 2x6 sessions of physical therapy directed to the back is not demonstrated to be medically necessary over the recommended self-directed home exercise program. The patient has exceeded the CA MTUS recommended time period for rehabilitation of a lower back strain or lumbar radiculopathy.