

<b>Case Number:</b>	CM13-0024329		
<b>Date Assigned:</b>	06/06/2014	<b>Date of Injury:</b>	03/21/2011
<b>Decision Date:</b>	01/06/2015	<b>UR Denial Date:</b>	08/14/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/13/2013

### 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 Orthopedic Surgery, has a subspecialty in Internal 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:

The patient is an injured worker with neck, back, and upper extremity complaints. Date of injury was 03-30-2011. MRI magnetic resonance imaging of lumbosacral spine was performed on April 10, 2013. Loss of intervertebral disc height and disc desiccation changes are seen at the L2-L3, L4-L5 and L5-S1 levels with straightening of the normal lumbar spine lordosis with slight levoscoliotic deformity. No prevertebral soft tissue abnormalities are seen. At the L5-S1 and L4-L5 levels, annular concentric and right greater than left broad-based measuring 4-5 mm disc protrusions present at both levels. Right paracentral annular tears is noted. There is no extrusion or sequestration of the disc material. Mild to moderate right greater than left lateral spinal more at the L5-S1 level and neural foraminal stenosis present. At the L1-L2 level, annular concentric broad-based 3.5 mm disc protrusion is seen, flattening and abutting the anterior portion of the thecal sac with mild bilateral lateral spinal and neural foraminal stenosis. There is no extrusion or sequestration of the disc material. No fracture, dislocation or subluxation. There are no focal bone marrow abnormalities. The spinal cord normally ends at the T12 level. The conus is unremarkable. The limited view of the prevertebral soft tissues is normal. Loss of intervertebral disc height and disc desiccation changes are seen at the L2-L3, L4-L5 and L5-S1 levels with straightening of the normal lumbar spine lordosis with slight levoscoliotic deformity. No prevertebral soft tissue abnormalities are seen. No spondylolisthesis or spondylolysis is seen. The initial psychiatric evaluation report dated May 16, 2013 documented subjective complaints of depressed mood and back pain. Medications included Prozac, Xanax, Synthroid, Imitrex, Lasix, Norvasc, Prilosec, Reglan, Microzide (Hydrochlorothiazide), and Benicar. The patient has had history of hypertension, hypothyroid, irritable bowel syndrome, acid reflux, and migraine. The patient lives with spouse and has two children. There is no history of tobacco abuse. Objective findings were documented. The patient walks with a normal gait. Motor activity was

normal. Memory, attention, and concentration were normal. Diagnoses included depressive disorder, anxiety disorder, insomnia, hypertension, hypothyroidism, irritable bowel syndrome, migraine, and chronic pain. Treatment plan was documented. The patient has been prescribed Zoloft, Klonopin, and BuSpar. The primary treating physician's progress report dated 5/21/13 documented subjective complaints of neck, low back, bilateral hands, shoulder pain. Injection of left wrist helped. Objective findings were documented. The results of the 4/10/13 MRI were noted. Regarding the physical examination, no changes to physical examination were noted. Diagnoses were cervical sprain, lumbosacral radiculopathy, bilateral carpal tunnel syndrome, bilateral shoulder sprain strain, depression, and anxiety. Treatment plan included continuation of physical therapy. The secondary treating physician's progress report dated 5/30/13 documented subjective complaints of bilateral hand pain and left elbow pain. Physical examination was documented. The patient is a well-developed and well-nourished female, in no apparent distress. She appears her stated age. Examination of the bilateral hands revealed bilateral positive Phalen test, bilateral positive Tinel sign, and bilateral positive compression test of the median nerve with numbness in the thumb, index, and middle finger of approximately 5 seconds. Bilateral thenar atrophy and bilateral abductor pollicis brevis weakness. Bilateral negative Finkelstein test. Bilateral negative pain over the first dorsal wrist extensor. Bilateral negative pain in the anatomic snuffbox. Bilateral negative pain on ulnar and radial deviation of the wrist. Bilateral negative pain on wrist flexion and wrist extension. Bilateral negative pain over the bilateral medial epicondyles. Positive pain over the right lateral epicondyle. No pain over the left lateral epicondyle. No pain over the bilateral antecubital fossa. No pain over the bilateral olecranon. No pain in the elbow. No crepitus in the elbow bilaterally. No crepitus in the wrist bilaterally. Compartments are soft bilaterally. No pain over the bilateral cubital tunnel. No pain over the bilateral Guyon's canal. Bilateral elbow range of motion was normal. Utilization review decision date was 8/12/13.

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

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

**Lumbar Epidural Steroid Injection, unknown levels:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46.

**Decision rationale:** Medical Treatment Utilization Schedule (MTUS) addresses epidural steroid injections (ESIs). American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 12 Low Back Complaints (Page 300) states that invasive techniques (e.g., local injections and facet-joint injections of cortisone and lidocaine) are of questionable merit. Epidural steroid injections treatment offers no significant long-term functional benefit, nor does it reduce the need for surgery. Chronic Pain Medical Treatment Guidelines (Page 46) states that epidural steroid injections (ESIs) are recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). The American Academy of Neurology concluded that epidural steroid injections do not affect

impairment of function or the need for surgery and do not provide long-term pain relief. ESI treatment alone offers no significant long-term functional benefit. Criteria for the use of epidural steroid injections requires that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. The initial psychiatric evaluation report dated May 16, 2013 documented that the patient walks with a normal gait and motor activity was normal. The primary treating physician's progress report dated 5/21/13 did not document a lumbosacral physical examination. The first two pages of the secondary treating physician's progress report dated 5/30/13 were submitted. The remaining pages were not submitted. The partial copy of the 5/30/13 progress report did not document a lumbosacral physical examination. The reports dated 5/16/13, 5/21/13, and 5/30/13 were the latest progress reports submitted for review. Physical examination of the lumbosacral spine was not documented in the 5/16/13, 5/21/13, and 5/30/13 reports. Per MTUS, criteria for the use of epidural steroid injections requires that radiculopathy must be documented by physical examination. Because physical examination of the lumbosacral spine were not documented, the request for lumbar epidural steroid injection is not supported. Therefore, the request for lumbar epidural steroid injection, unknown levels is not medically necessary.

#### **Cane for Lumbar Spine: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg (Acute & Chronic) Walking aids

**Decision rationale:** Medical Treatment Utilization Schedule (MTUS) does not address walking aids. Official Disability Guidelines (ODG) states that disability, pain, and age-related impairments seem to determine the need for a walking aid. Nonuse is associated with less need, negative outcome, and negative evaluation of the walking aid. The initial psychiatric evaluation report dated May 16, 2013 documented that the patient walks with a normal gait and motor activity was normal. The primary treating physician's progress report dated 5/21/13 did not document a lumbosacral and lower extremities physical examination. The first two pages of the secondary treating physician's progress report dated 5/30/13 were submitted. The remaining pages were not submitted. The partial copy of the 5/30/13 progress report did not document a lumbosacral and lower extremities physical examination. The reports dated 5/16/13, 5/21/13, and 5/30/13 were the latest progress reports submitted for review. Physical examination of the lumbosacral spine and lower extremities were not documented in the 5/16/13, 5/21/13, and 5/30/13 reports. The 5/16/13 progress report documented that the patient walks with a normal gait and motor activity was normal. Therefore, the request for a cane is not supported. Therefore, the request for cane for lumbar spine is not medically necessary.

#### **Back Brace for Lumbar Spine: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

**Decision rationale:** Medical Treatment Utilization Schedule (MTUS) addresses lumbar supports. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 12 Low Back Complaints (Page 301) states that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. ACOEM 3rd edition occupational medicine practice guidelines (2011) state that lumbar supports are not recommended for the treatment of low back disorders. Lumbar supports are not recommended for prevention of low back disorders. The initial psychiatric evaluation report dated May 16, 2013 documented that the patient walks with a normal gait and motor activity was normal. The primary treating physician's progress report dated 5/21/13 did not document a lumbosacral physical examination. The first two pages of the secondary treating physician's progress report dated 5/30/13 were submitted. The remaining pages were not submitted. The partial copy of the 5/30/13 progress report did not document a lumbosacral physical examination. The reports dated 5/16/13, 5/21/13, and 5/30/13 were the latest progress reports submitted for review. Physical examination of the lumbosacral spine were not documented in the 5/16/13, 5/21/13, and 5/30/13 reports. MTUS and ACOEM guidelines do not support the medical necessity of lumbar supports. Therefore, the request for back brace is not medically necessary.

**Physical Therapy X12 Sessions for Back, Bilateral Shoulders, Elbows, and Wrists:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Physical Therapy

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

**Decision rationale:** Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines provide physical therapy (PT) physical medicine guidelines. For myalgia and myositis, 9-10 visits are recommended. For neuralgia, neuritis, and radiculitis, 8-10 visits are recommended. The initial psychiatric evaluation report dated May 16, 2013 documented that the patient walks with a normal gait and motor activity was normal. The primary treating physician's progress report dated 5/21/13 did not document a lumbosacral physical examination. The first two pages of the secondary treating physician's progress report dated 5/30/13 were submitted. The remaining pages were not submitted. The partial copy of the 5/30/13 progress report did not document a lumbosacral physical examination. The reports dated 5/16/13, 5/21/13, and 5/30/13 were the latest progress reports submitted for review. Physical examination of the lumbosacral spine was not documented in the 5/16/13, 5/21/13, and 5/30/13 reports. The primary treating physician's progress report dated 5/21/13 documented a treatment plan to continue physical therapy, indicating that the patient was participating in physical therapy. No functional improvement with past PT physical therapy treatments were documented. MTUS guidelines allow for up to 10 physical therapy visits. The request for 12 additional PT physical therapy sessions would exceed MTUS guideline recommendations. No exceptional factors justifying

exceeding MTUS guideline recommendations were documented. The request for 12 additional PT physical therapy sessions is not supported. Therefore, the request for physical therapy x12 sessions for back, bilateral shoulders, elbows, and wrists is not medically necessary.

**Topical Compound Medications for Back, Bilateral Shoulders, Elbows, and Wrists: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

**Decision rationale:** Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines address topical analgesics. Topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The initial psychiatric evaluation report dated May 16, 2013 documented that the patient walks with a normal gait and motor activity was normal. The primary treating physician's progress report dated 5/21/13 did not document a lumbosacral physical examination. The first two pages of the secondary treating physician's progress report dated 5/30/13 were submitted. The remaining pages were not submitted. The partial copy of the 5/30/13 progress report did not document a lumbosacral physical examination. The reports dated 5/16/13, 5/21/13, and 5/30/13 were the latest progress reports submitted for review. Physical examination of the lumbosacral spine was not documented in the 5/16/13, 5/21/13, and 5/30/13 reports. The request for topical compound medications did not specify the specific medications contained in the topical compound product. In general, MTUS guidelines do support the use of topical compound medications. The request for topical compound medications is not supported. Therefore, the request for topical compound medications for back, bilateral shoulders, elbows, and wrists is not medically necessary.

**Genetic Testing for Narcotic Risk Secondary to Back, Bilateral Shoulder, Elbow, and Wrist: Upheld**

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

**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) Cytochrome P450 testing Cytokine DNA testing Genetic testing for potential opioid abuse

**Decision rationale:** Medical Treatment Utilization Schedule (MTUS) does not address genetic testing. Official Disability Guidelines (ODG) state that Cytochrome P450 testing is not recommended. Cytokine DNA testing is not recommended. There is no current evidence to support the use of cytokine DNA testing for the diagnosis of pain, including chronic pain. Cytochrome P450 testing is not recommended. Genetic testing for potential opioid abuse is not recommended. Official Disability Guidelines (ODG) do not recommend genetic testing for

potential opioid abuse. Therefore, the request for genetic testing for narcotic risk secondary to back, bilateral shoulder, elbow, and wrist is not medically necessary.