

Case Number:	CM14-0197609		
Date Assigned:	12/05/2014	Date of Injury:	10/22/2014
Decision Date:	01/21/2015	UR Denial Date:	11/09/2014
Priority:	Standard	Application Received:	11/25/2014

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 Internal Medicine, has a subspecialty in Rheumatology, Allergy and Immunology and is licensed to practice in Texas. 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 64 year old female with a date of injury of 10/22/14 of a fall while pushing a surgical tray resulting in hitting a door jam and the tray falling upon her back. The patient was initially seen by an occupational medicine provider on 10/22/14. She was then seen the following day by the requesting provider. She is being treated for lumbar sprains and strains with contusion and ecchymosis, bilateral upper extremity-elbow contusions, cervical degenerative disc disease, lumbar degenerative disc disease post-arthroscopy right knee (non-work related) and bilateral lower extremity contusions. She does not have a history of osteoporosis. Subjective complaints on 10/23/14 include 5-10/10 lumbar pain increasing with twisting, left lumbosacral burning/stabbing pain on left and a denial of both neurological symptoms and red flag symptoms. Objective findings include jolting reaction to twisting, guarded gait, forward flexion of 10 degrees on standing, tenderness at the lumbosacral spine (central and left) increasing with a jolting reaction upon twisting 20 degrees left and right, extension is 10 degrees and increases pain, ecchymosis is present along lumbosacral spine and up left paravertebral muscles with tenderness, spasms and guarding. Cervical spine as limited rotation bilaterally with discomfort and paravertebral muscle tightness, shoulders are unremarkable and slight tenderness in both elbows. Lumbar imaging was requested by the occupational medicine provider on 10/22/14 on the day of her injury with no acute findings noted by the requesting provider, official reading not available. Repeat lumbar x-rays with flexion and extension views 10/23/14 were requested and demonstrated degenerative changes with no gross fractures. Treatment thus far has consisted of pain management (Percocet, cyclobenzaprine, lamotrigine, soma and sertraline), chiropractic, medications and injection of Ketorolac plus Lidocaine at the left lumbosacral region and left side, trigger point injection of Kenalog and Marcaine, and dexamethasone injection. Follow up on 10/27/14 demonstrates continued pain and worsening ecchymosis but no new neurological or

red flag symptoms. Utilization review on 11/09/14 rendered a decision for Toradol with anesthetic trigger point injection on 10/23/14 modified to approve Toradol injection only, a non-certified for repeat lumbar x-rays with flexion and extension on 10/27/14, and a non-certified for Lumbar Corset on 10/23/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request for repeat lumbar x-rays with flexion and extension on 10/27/2014:
Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation ODG, Low Back

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Radiography (x-rays)

Decision rationale: American College of Occupational and Environmental Medicine (ACOEM) and Official Disability Guidelines (ODG) both agree that "Lumbar spine x rays should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least six weeks." The medical notes provided do not document (physical exam, objective testing, or subjective complaints) a concern for possible serious spinal pathology of the lumbar spine as outlined in the ODG guidelines. Films requested by the occupational medicine provider and performed on 10/22/14 had an unofficial read of no acute findings. Follow up appointment with the current provider on 10/23/14 fails to demonstrate a significant worsening of her symptoms, neurological deficits or red flag symptoms. Repeat films ordered and performed on 10/23/14 with bending failed to demonstrate any significant pathology. ODG further specifies other indications for imaging with Plain X-rays: Thoracic spine trauma: severe trauma, pain, no neurological deficitThoracic spine trauma: with neurological deficitLumbar spine trauma (a serious bodily injury):pain, tendernessLumbar spine trauma: trauma, neurological deficitLumbar spine trauma: seat belt (chance) fractureUncomplicated low back pain, trauma, steroids, osteoporosis, over 70Uncomplicated low back pain, suspicion of cancer, infectionMyelopathy (neurological deficit related to the spinal cord), traumaticMyelopathy, painfulMyelopathy, sudden onsetMyelopathy, infectious disease patientMyelopathy, oncology patientPost-surgery: evaluate status of fusionThis is request for repeat lumbar spine imaging with flexion and extension. The patient was seen on 10/22/14, the date of her injury, by an occupational medicine provider and referred for lumbar spine imaging. Official report is not available but records indicate that the results were without acute findings. She was seen by the requesting provider on 10/23/14. Per the medical records, no attempt was made to obtain the previous imaging or report. The physician note (PR2) does not document any red flags for serious spinal pathology. The provider fails to provide adequate rationale for repeat imaging as recommended by ACOEM and ODG guidelines. The 10/23/14 repeat lumbar x-ray with flexion and extension demonstrates degenerative changes but no significant pathology. Of note, the Utilization Review, requesting physician appeal and IMR state a request on 10/27/14 for repeat lumbar film with flexion and extension. This date appears to be an error

as the request was made on 10/23/14. As discussed above, the request for Repeat Lumbar X-ray with flexion and extension on 10/27/14 is not medically necessary.

Lumbar corset: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation ODG- Low Back

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back (Lumbar and Thoracic), Lumbar Support

Decision rationale: American College of Occupational and Environmental Medicine (ACOEM) states, "Lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief." The Official Disability Guidelines (ODG) states, "Not recommended for prevention. Recommended as an option for treatment. See below for indications. Prevention: Not recommended for prevention. There is strong and consistent evidence that lumbar supports were not effective in preventing neck and back pain. (Jellema-Cochrane, 2001) (van Poppel, 1997) (Linton, 2001) (Assendelft-Cochrane, 2004) (van Poppel, 2004) (Resnick, 2005) Lumbar supports do not prevent LBP. (Kinkade, 2007) A systematic review on preventing episodes of back problems found strong, consistent evidence that exercise interventions are effective and other interventions not effective, including stress management, shoe inserts, back supports, ergonomic/back education, and reduced lifting programs. (Bigos, 2009) This systematic review concluded that there is moderate evidence that lumbar supports are no more effective than doing nothing in preventing low-back pain. (van Duijvenbode, 2008)". ODG states for use as a treatment "Treatment: Recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific LBP (very low-quality evidence, but may be a conservative option)." The patient is being treated for lumbar sprains and strains with contusion and ecchymosis. There is no documentation of the ACOEM and ODG recommended indications of compression fractures, spondylolisthesis or documented spinal instability in the record. Although lumbar support may be used in the treatment of nonspecific LBP, the quality of evidence is poor and larger systemic reviews concluded that it is no more effective than doing nothing. As such the request for lumbar corset is not medically necessary.

Retrospective request for Toradol with anesthetic trigger point injections on 10/23/2014: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation ODG Low Back

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger point injections Page(s): 122.

Decision rationale: California MTUS states that Trigger Point Injections are "Recommended only for myofascial pain syndrome as indicated below, with limited lasting value. Not

recommended for radicular pain." And further states that "trigger point is a discrete focal tenderness located in a palpable taut band of skeletal muscle, which produces a local twitch in response to stimulus to the band . . . For fibromyalgia syndrome, trigger points injections have not been proven effective." MTUS lists the criteria for Trigger Points: (1) Documentation of circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain; (2) Symptoms have persisted for more than three months; (3) Medical management therapies such as ongoing stretching exercises, physical therapy, NSAIDs and muscle relaxants have failed to control pain; (4) Radiculopathy is not present (by exam, imaging, or neuro-testing); (5) Not more than 3-4 injections per session; (6) No repeat injections unless a greater than 50% pain relief is obtained for six weeks after an injection and there is documented evidence of functional improvement; (7) Frequency should not be at an interval less than two months; (8) Trigger point injections with any substance (e.g., saline or glucose) other than local anesthetic with or without steroid are not recommended. MTUS further goes on to state, "Trigger point injections with any substance (e.g., saline or glucose) other than local anesthetic with or without steroid are not recommended." (Colorado, 2002) In this case, Toradol with anesthetic trigger point injections was requested for the treatment of an acute lumbosacral sprain due to a fall. The patient does have an area of acute pain causing jolting upon twisting but there is no history of myofascial pain syndrome with symptoms persisting 3 months, evidence of failure of physical therapy, NSAIDs and muscle relaxers as recommended by the MTUS guidelines. The therapy with Toradol alone would seem reasonable and necessary for the treatment of acute pain as determined by the previous UR's modification and given a positive response by the patient to it. However, given that the treatment was given for acute pain and not chronic myofascial pain as a whole, the request for Toradol with anesthetic trigger point injection is at this time not medically necessary. Furthermore, trigger point injections with substances, Toradol in this case, other than local anesthetic with or without steroid are not recommended MTUS and thus the request for Toradol with anesthetic trigger point injection is not medically necessary.