

<b>Case Number:</b>	CM15-0161273		
<b>Date Assigned:</b>	08/28/2015	<b>Date of Injury:</b>	08/13/2013
<b>Decision Date:</b>	10/05/2015	<b>UR Denial Date:</b>	07/29/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/18/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Illinois, California, Texas

Certification(s)/Specialty: Orthopedic Surgery

### 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 injured worker is a 49-year-old male who sustained an industrial injury on 8/13/13. Injury occurred while he was trying to shut off a gas line valve and twisted toward the left pulling on the wrench. He experienced an onset of pain radiating from the middle of the thoracic spine at the T8 or T9 level to the flanks and across to the abdomen. Past medical history was positive for Crohn's disease. Conservative treatment included physical therapy, trigger point injections, epidural steroid injections, and medication. Records indicated that two epidural steroid injections were provided in July and September 2014 which were not helpful. Intercostal nerve blocks were provided bilaterally at T8, T9, and T10 on 1/14/15 with no significant benefit. The 7/6/15 rib x-ray series documented mild cortical irregularity of the distal lateral 10th rib on right. The 7/17/15 bilateral lower extremity electrodiagnostic findings suggested possible L5 and S1 radiculopathy on both sides, more on the right. The 7/17/15 thoracic spine MRI impression documented a 2-3 mm T9/10 paracentral disc protrusion, left greater than right. At T11/12, there was a 4 mm disc protrusion which indented the anterior thecal sac and spinal cord. This was more prominent on the left than the right, and caused mild neuroforaminal narrowing bilaterally with no significant central canal stenosis. The 7/17/15 treating physician report cited severe low back pain, and neck and arm pain. He was unable to ride in a car. He reported riding a motorcycle was more comfortable, leaning forward. Physical exam documented low back pain, parathoracic tenderness with muscle spasms, and pain with hyperextension on the right at T7-9. He had some neck and lower back tenderness with numbness in the last three fingers. The diagnosis was thoracic disc disorder. Bilateral thoracic facet injections/nerve blocks were performed at T9 and T11 bilaterally. Authorization was requested for microdecompression

discectomy thoracic levels T9 and T11, intercostal nerve block, right side T10, and compound cream #3 - Ketoprofen 10%, Baclofen 5%, Gabapentin 5%, and Ketamine 5%, quantity 1. The 7/29/15 utilization review non-certified the microdecompression discectomy at thoracic levels T9 and T11 as there was no clear evidence for thoracic radiculopathy despite the disc protrusion on MRI and burning back pain had been addressed by medial branch blocks at T9 and T11. The request for intercostal nerve block, right side T10, was non-certified as the injured worker had failed prior bilateral intercostal nerve blocks at T8-10. The request for compound cream #3 was non-certified as Ketoprofen, Baclofen, gabapentin and ketamine were not recommended by guidelines for topical use.

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

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

#### **Microdecompressive Discectomy, Thoracic, levels T9 and T11: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back - Percutaneous endoscopic lumbar discectomy.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back & Lumbar & Thoracic: Discectomy/Laminectomy.

**Decision rationale:** The California MTUS recommend surgical consideration when there is severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise. Guidelines require clear clinical, imaging and electrophysiologic evidence of a lesion that has been shown to benefit both in the short term and long term from surgical repair. The guidelines recommend that clinicians consider referral for psychological screening to improve surgical outcomes. The Official Disability Guidelines recommend criteria for thoracolumbar discectomy that include symptoms/findings that confirm the presence of radiculopathy and correlate with clinical exam and imaging findings. Guideline criteria include evidence of nerve root compression, imaging findings of nerve root compression, lateral disc rupture, or lateral recess stenosis, and completion of comprehensive conservative treatment. Guideline criteria have not been met. This injured worker presents with severe low back pain, neck and arm pain. There is imaging evidence of a T 11/12 disc protrusion with plausible neural compression, and a T9/10 paracentral disc protrusion, left greater than right with no evidence of neural compression. There are no clinical exam findings documented suggestive of thoracic nerve root compromise. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has not been submitted. Bilateral facet nerve blocks were performed on 7/17/15 with no documentation of failure to provide relief. There is no evidence that other plausible overall pain generators have been fully addressed. Therefore, this request is not medically necessary at this time.

#### **Associated Surgical Services: Intercostal Nerve Block, right side, Thoracic T10: 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 Hwang EG, Lee Y. Effectiveness of intercostal nerve block for management of pain in rib fracture patients. J Exerc Rehabil. 2014 Aug 31; 10(4): 241- 4. doi: 10.12965/jer. 140137. eCollection 2014.

**Decision rationale:** The California MTUS and Official Disability Guidelines do not provide recommendations for intercostal thoracic nerve blocks. Peer reviewed literature support the use of intercostal nerve blocks for effective pain control, in comparison to conventional medications, in the initial stage of treatment of patients with thoracic injuries. The injured worker has undergone prior intercostal thoracic nerve blocks without significant pain relief. There is no compelling rationale submitted to support the medical necessity of repeat nerve blocks in the absence of prior benefit. Therefore, this request is not medically necessary.

**Associated Surgical Services: Compound cream #3 - Ketoprofen 10%, Baclofen 5%, Gabapentin 5%, Ketamine 5%, Qty 1: 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:** The California MTUS guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Topical agents are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support the use of many of these agents. Guidelines state that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Guidelines state that Ketoprofen is not FDA-approved for topical use given the extremely high incidence of photocontact dermatitis. Topical Baclofen and gabapentin are not recommended by guidelines as there is no peer-reviewed evidence to support use of these medications topically. Ketamine is under study and only recommended for treatment of neuropathic pain in refractory cases where all primary and secondary treatment has been exhausted. Given the failure to meet guideline criteria for the use of all components in this compounded topical analgesic, use of this compound cream is not recommended. Therefore, this request is not medically necessary.