

<b>Case Number:</b>	CM14-0122229		
<b>Date Assigned:</b>	09/16/2014	<b>Date of Injury:</b>	11/19/2012
<b>Decision Date:</b>	11/06/2014	<b>UR Denial Date:</b>	07/14/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/01/2014

### 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 Occupational Medicine and is licensed to practice Illinois. 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 injured worker is a 25 year old male with a date of injury on 11/19/12. He injured his back while carrying buckets of water to wash floors. Per doctors note on 3/3/14, has a shoulder arthropathy, lumbar disc protrusion and a cervical disk bulge. The worker states he can't sleep at night and has pain all the time. The injured worker has been referred to chiropractic care and acupuncture. The provider notes are largely illegible.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cervical Epidural Steroid Injection at C4-5 With Local Anesthetics:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46.

**Decision rationale:** The purpose of an epidural steroid injection (ESI) is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. 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). Per the Medical Treatment Utilization Schedule (MTUS), the criteria for the use of epidural steroid injections include: 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, non-steroidal anti-inflammatory drugs [NSAIDs] and muscle relaxants). 3) Injections should be performed using fluoroscopy (live x-ray) for guidance. 4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections. 5) No more than two nerve root levels should be injected using transforaminal blocks. 6) No more than one interlaminar level should be injected at one session. 7) In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. There is no documentation about which conservative modalities the worker has tried, including physical therapy and medications such as non-steroidal anti-inflammatory drugs (NSAIDs)/muscle relaxants, and what the results of those therapies were. Therefore the request is not medically necessary.

**Compound Cream: Ketoprofen/Lidocaine 20/10%:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 112-113.

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

**Decision rationale:** The Medical Treatment Utilization Schedule (MTUS) states that if one drug (or drug class) in the compounded product is not recommended, then the entire compound is not recommended. The medication- compound Ketoprofen/Lidocaine is not medically necessary/appropriate. Ketoprofen is not recommended. There is no peer-reviewed literature to support its use. In addition, in the provider's notes where this topical medication is ordered, there are no specific instructions on how and where to use this medication. Therefore, this request is not medically necessary.

**Compound Cream: Gabapentin/Ketoprofen/Lidocaine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 112-113.

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

**Decision rationale:** The Medical Treatment Utilization Schedule (MTUS) states that if one drug (or drug class) in the compounded product is not recommended, then the entire compound is not recommended. The medication- compound gabapentin/ketoprofen/lidocaine is not medically necessary/appropriate. Gabapentin is not recommended. There is no peer-reviewed literature to

support its use. In addition, in the treating physician's notes, where this topical medication is ordered, there are no specific instructions on how and where to use this medication. Therefore, this request is not medically necessary.

**Tramadol 50mg, Unspecified Quantity: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 81.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Tramadol (Ultram) Page(s): 76,113.

**Decision rationale:** Tramadol (Ultram) is a centrally acting synthetic opioid analgesic. Central acting analgesics are an emerging fourth class of opiate analgesic that may be used to treat chronic pain. This small class of synthetic opioids (e.g., tramadol) exhibits opioid activity and a mechanism of action that inhibits the reuptake of serotonin and norepinephrine. Central analgesic drugs such as tramadol (Ultram) are reported to be effective in managing neuropathic pain. Side effects are similar to traditional opioids. Tramadol is not recommended by the evidence based guidelines as a first-line oral analgesic. There is no documentation that this worker has been tried on a first-line medication. The request is not medically necessary.

**Cold Therapy Unit: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Treatment in Workers/Comp, 9th Edition (web), Cold Therapy

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Continuous-flow cryotherapy Official Disability Guidelines (ODG) Knee and Leg, Continuous-flow cryotherapy

**Decision rationale:** Cold therapy is not addressed in Medical Treatment Utilization Schedule (MTUS). Per the Official Disability Guidelines (ODG) continuous-flow cryotherapy is recommended as an option after some surgeries. Postoperative use generally may be up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect on more frequently treated acute injuries (eg, muscle strains and contusions) has not been fully evaluated. Continuous-flow cryotherapy units provide regulated temperatures through use of power to circulate ice water in the cooling packs. Complications related to cryotherapy (i.e., frostbite) are extremely rare but can be devastating. This worker has not had a surgery, so he doesn't meet the criteria for a cold therapy unit. The request is not medically necessary.

**Interferential ( IF) Unit: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118.

**Decision rationale:** Per the Medical Treatment Utilization Schedule (MTUS), Interferential Current Stimulation (ICS) is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain and post-operative knee pain. The findings from these trials were either negative or non-interpretable for recommendation due to poor study design and/or methodologic issues. In addition, although proposed for treatment in general for soft tissue injury or for enhancing wound or fracture healing, there is insufficient literature to support interferential current stimulation for treatment of these conditions. There are no standardized protocols for the use of interferential therapy; and the therapy may vary according to the frequency of stimulation, the pulse duration, treatment time, and electrode-placement technique. Two recent randomized double-blind controlled trials suggested that interferential current stimulation (ICS) and horizontal therapy (HT) were effective in alleviating pain and disability in injured workers with chronic low back pain compared to placebo at 14 weeks, but not at 2 weeks. The placebo effect was remarkable at the beginning of the treatment but it tended to vanish within a couple of weeks. The studies suggested that their main limitation was the heterogeneity of the low back pain subjects, with the interventions performing much better for back pain due to previous multiple vertebral osteoporotic fractures, and further studies are necessary to determine effectiveness in low back pain from other causes. A recent industry-sponsored study in the Knee Chapter concluded that interferential current therapy plus patterned muscle stimulation (using the RS-4i Stimulator) has the potential to be a more effective treatment modality than conventional low-current transcutaneous electrical neurostimulator (TENS) for osteoarthritis of the knee. This recent randomized controlled trial (RCT) found that either electroacupuncture or interferential electrotherapy, in combination with shoulder exercises, is equally effective in treating frozen shoulder injured workers. It should be noted that this study only showed the combined treatment effects with exercise as compared to no treatment, so the entire positive effect could have been due to the use of exercise alone. While not recommended as an isolated intervention, injured worker selection criteria if interferential stimulation is to be used anyway: Possibly appropriate for the following conditions if it has documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical medicine:

- Pain is ineffectively controlled due to diminished effectiveness of medications; or
- Pain is ineffectively controlled with medications due to side effects; or
- History of substance abuse; or
- Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or
- Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.).

If those criteria are met, then a one-month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits. There should be evidence of increased functional improvement, less reported pain and evidence of medication reduction. A "jacket" should not be certified until after the one-month trial and only with documentation that the individual cannot apply the stimulation pads alone or with the help of another available person. These criteria have not been met in this worker, as there is no documentation to suggest that his pain has been ineffectively controlled with medication or that he has not responded to conservative measures.