

<b>Case Number:</b>	CM14-0215720		
<b>Date Assigned:</b>	01/05/2015	<b>Date of Injury:</b>	07/12/2014
<b>Decision Date:</b>	06/03/2015	<b>UR Denial Date:</b>	11/20/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/23/2014

### 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. 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: New York

Certification(s)/Specialty: Anesthesiology

### 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 35 year old carpenter on 07/12/2014 fell off a ladder lacerating his left forehead, fracturing his left patella and incurring a non displaced skull fracture thru the left frontal sinus. He had a brief loss of consciousness and complained of left wrist pain. Past history included prior left wrist fracture. Initial computerized tomography scan and magnetic resonance scan of the cervical spine showed no acute injury. His pain was treated with Dilaudid; he was discharged from hospital on antibiotics. He returned to hospital on 7/25/14 complaining of severe headaches worsened by watching television, bright lights, loud noise and children. He complained of morning confusion and speaking slowly and incorrectly. A diagnosis of post concussive syndrome was made and Norco 5-325, and Lorazepam .5 mg. twice a day was prescribed. Follow up orthopedic recommendation on 07/29/24 was for an open reduction internal fixation (ORIF) of the left patellar fracture. On 7/17/2014 home health physical therapy was requested and denied. Diagnoses were comminuted left patellar fracture, contusion forehead, sprain cervical spine, sprain left wrist and sprain of lumbosacral spine. A neurology consultation was requested with electroencephalogram (EEG), polysomnogram and electromyogram, (EMG) and nerve conduction studies to rule out a radiculopathy. The EEG and polysomnograms were normal. On 8/7/2014 the ORIF of the left patella was accomplished. The following morning an ambulance was requested to return the injured worker to hospital because of severe knee pain which was treated with 2 mg. of intramuscular Dilaudid and 4 mg of Zofran with good relief. On 8/10/2014 ambulance was again called because the pain medications were not working. Progress notes by the orthopedist noted his pain was slightly better on 9/3/14 and better on 9/15/2014. On the 9/25/2014 Neurology visit the injured worker had complaints of left

leg, neck and low back pain. His wife was helping him wash and dress requiring four hours a day of attention. On 10/13/2014 his pain was better and he had less knee stiffness. X-rays showed no patellar fracture line. The neurologist prescribed Naproxen Sodium DS 550 mg and authorization of 4 hours/day/7days/wk by the wife which was denied by Utilization review on 11/18/2014. The independent medical review (IMR) of the requested 18 post-op physical therapy sessions recommended denial per MTUS guidelines on 10/16/2014. A subsequent request for authorization was made for a Toradol cervical injection, physical therapy 2 x 6 to the neck and low back consisting of diathermy, EMS, ultrasound, massage, as well as physical therapy to the left knee and chiropractic manipulation to the neck and low back 1 x 6. Utilization review denied this on 11/20/2014 on which date an independent medical review (IMR) was requested. Then on 10/20/2014 Authorization for Vitamin B Complex injection, physical therapy 2 x 4 to left knee, neck and lower back was requested as well for Flexeril 20 mg. #60. The flexeril was modified to 45, and the others denied.

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

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

**Toradol injection 60mg:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Toradol Page(s): 72.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Ketorolac (Toradol). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) MTUS page 72.

**Decision rationale:** Ketorolac (Toradol) is a non-steroidal anti-inflammatory drug (NSAID). The oral form is only recommended for short-term (up to 5 days) management of moderately severe acute pain that requires analgesia at the opioid level, and only as continuation following IV or IM dosing, if necessary. This medication is not indicated for minor or chronic painful conditions. Dosing is always started with parenteral therapy and oral administration is indicated only as a continuation of intravenous (IV)/intramuscular (IM) dosing, if necessary. The single IV dose is 30mg, with a dose of 30mg every 6 hours, not to exceed 120 mg/day. The single IM dose is 60mg or 30mg every 6 hours, not to exceed 120 mg/day. The oral dose is 20mg once after IV or IM therapy, then 10mg every 4-6 hours, not to exceed 40 mg/day. The guidelines do not recommend Toradol for chronic pain, as in this case. In addition, it is unclear if the Toradol administration requested is for IV or IM injection. Medical necessity for a Toradol injection has not been established. The requested medication is not medically necessary.

**Vitamin B complex injection:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Treatment index, 12th Edition.

**Decision rationale:** Vitamin B-complex includes eight distinct vitamins: thiamin, riboflavin, niacin, pantothenic acid, pyridoxine, biotin, folic acid, and cyanocobalamin, plus para-aminobenzoic acid, inositol, and choline. Water soluble B-complex vitamins assist in metabolism, promote skin and muscle tone, help the immune and nervous system and are essential for cell growth and division. According to the ODG, vitamin B-complex is not recommended for the treatment of chronic pain unless this is associated with documented vitamin deficiency. Research showed that there are only limited data in randomized trials testing the efficacy of vitamin B for treating peripheral neuropathy (diabetic and alcoholic). Evidence was insufficient to determine whether specific B vitamins or B complex for these conditions was beneficial or harmful. In this case, there is no documentation of subjective or objective functional benefit with prior medication use. Medical necessity for the requested Vitamin B-complex injection has not been established. The requested medication is not medically necessary.

**Physical therapy 2 x 4 for the left knee:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy Page(s): 24. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Physical Therapy.

**Decision rationale:** According to the California MTUS Treatment guidelines, physical therapy (PT) is indicated for the treatment of musculoskeletal pain. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. The physical therapy prescription should include diagnosis; type, frequency, and duration of the prescribed therapy; preferred protocols or treatments; therapeutic goals; and safety precautions (e.g., joint range-of-motion and weight-bearing limitations, and concurrent illnesses). According to the ODG, physical therapy for post-surgical treatment of a patella fracture (ORIF), as in this patient (8/7/14), is 30 visits over 12 weeks. The documentation indicates that 10 post-operative visits were authorized (8/13/14), but the response to PT was unclear, as the patient continues to have ongoing subjective pain. Given that the guideline recommendations were not completed, medical necessity for requested PT sessions (2X4) has been established. The additional PT sessions are medically necessary.

**Physical therapy 2 x 4 for the neck:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 185, 181, 174, Chronic Pain Treatment Guidelines Physical Therapy Page(s): 98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper back.

**Decision rationale:** According to the California MTUS Treatment guidelines, physical therapy (PT) is indicated for the treatment of neck pain. The ODG recommends that for most patients with more severe and sub-acute neck pain conditions, up to 10 visits are indicated as long as functional improvement and program progression are documented. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assisting devices. In this case, there is no documentation of the number of previous PT treatments, to determine if the treatments completed have already exceeded the guideline recommendations. In addition, there is no documentation of subjective or objective improvement with previous treatment. Medical necessity for the requested service is not established. The requested service is not medically necessary.

**Physical therapy 2 x 4 for the low back:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy Page(s): 98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Lumbar Strain.

**Decision rationale:** According to the California MTUS Treatment guidelines, physical therapy (PT) is indicated for the treatment of musculoskeletal pain. Recommendations state that for most patients with more severe and sub-acute low back pain conditions, 8 to 12 visits over a period of 6 to 8 weeks is indicated as long as functional improvement and program progression are documented. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assisting devices. In this case, there is no documentation of how many physical therapy sessions were completed. There is no documentation indicating that he had a defined functional improvement in his condition. There is no specific indication for the requested additional PT sessions. Medical necessity for the requested PT sessions (2X4) has not been established. The requested PT is not medically necessary.

**Flexeril 20mg #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 64.

**Decision rationale:** According to the reviewed literature, Cyclobenzaprine (Flexeril) is not recommended for the long-term treatment of chronic pain. This medication has its greatest effect in the first four days of treatment. Guidelines state that this medication is not recommended to be used for longer than 2-3 weeks. According to CA MTUS Guidelines, muscle relaxants are not considered any more effective than non-steroidal anti-inflammatory medications alone. In this case, there are no muscle spasms documented on physical exam. There is no documentation of functional improvement from any previous use of this medication. Based on the currently available information, the medical necessity for this muscle relaxant medication has not been established. The requested medication is not medically necessary.