

Case Number:	CM15-0094921		
Date Assigned:	05/21/2015	Date of Injury:	06/06/2003
Decision Date:	06/29/2015	UR Denial Date:	04/14/2015
Priority:	Standard	Application Received:	05/15/2015

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:

The injured worker is a 59-year-old female who sustained industrial injury dated 6/06/03. Past medical history was positive for depression, anxiety, hypertension, and diabetes mellitus. Records documented conservative treatment to include lumbosacral rhizotomy, bilateral sacroiliac joint injections, activity modification and medications. The 8/14/06 EMG/NCV released a normal lower extremity exam with no evidence of a lumbar radiculopathy or focal neuropathy. The 1/14/10 bilateral hip x-ray impression documented degenerative changes in the sacroiliac joints and no evidence of disease in the hip joints. The 5/2/13 lumbar spine MRI impression documented disc bulges/protrusions at multiple levels. There was a left far lateral recess disc protrusion at L5/S1, which contacted the exiting left L5 nerve root. Findings documented a 1 to 2 mm retrolisthesis of L3 on L4 with disc bulge, mild biforaminal disc osteophyte ridging and moderate to severe facet arthropathy, resulting in mild to moderate neuroforaminal stenosis. There was contact of the exiting right L4 nerve root in the far lateral recess due to disc protrusion. At L4/5, there was contact of the left L5 nerve root in the far lateral recess due to the presence of a disc protrusion. The 3/24/15 pain management report cited continued low back and leg pain. Pain was reported grade 8/10 with medications, which were helping somewhat. Physical exam documented cervical spine tenderness and decreased flexion/extension. There was bilateral shoulder tenderness at the subacromial space, pain with resisted abduction, and decreased abduction. Lumbar spine exam documented spinal tenderness, facet joint tenderness, and range of motion decreased in flexion, extension, and lateral bending. The diagnosis was low back pain, lumbago, and shoulder region disorder. Medications were

prescribed to include Fluoromethane one can with three refills, ibuprofen 800 mg #90, and Norco 10/325 mg #200. A Toradol injection was provided. The treatment plan indicated that the patient had chronic low back pain that was not improving and needed surgery per the spine surgeon, authorization was requested. The 4/14/15 utilization review non-certified the request for surgery as per the neurosurgeon as this was documented as a request for lumbar spine discogram which lacks guidelines support. The request for Toradol 60 mg/2ml, 2 cc IM was non-certified as there is no little support for use for chronic pain and the injured worker was currently prescribed opioid therapy. The request for Fluoromethane was non-certified as there was no indication why such a product was necessary to complete the home stretching routine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fluori-Methane, 1 can with 3 refills: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back (Lumbar & Thoracic) (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM). Occupational Medical Practice Guidelines 2nd Edition. Chapter 12 Low Back Disorders. (Revised 2007) 160-161.

Decision rationale: Fluoromethane is an instant topical anesthetic spray refrigerant. The California MTUS guidelines generally support the use of at home cold packs and do not address the medical necessity of a topical refrigerant. The ACOEM Revised Low Back Disorder guidelines recommend self-applications of low-tech cryotherapies for the management of lower back pain. Other forms of cryotherapy, including chemical sprays are not recommended. Guideline criteria have not been met. There is no compelling reason to support the at home use of chemical spray cryotherapy over application of standard cold packs. Therefore, this request is not medically necessary.

Toradol 60 mg/2ml 2cc IM, 2 ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-73. Decision based on Non-MTUS Citation Official Disability Guidelines: Pain (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, specific drug list & adverse effects Page(s): 72. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic): Ketorolac (Toradol).

Decision rationale: The California Medical Treatment Utilization Schedule does not recommend Toradol for minor or chronic painful conditions. The Official Disability Guidelines indicate that Toradol administered intramuscularly may be used as an alternative to opioid

therapy. Guideline criteria have not been met. This patient presents with persistent chronic low back and leg pain. She is currently prescribed opioid medications. There is no compelling reason to support the medical necessity of Toradol as an alternative to current opioid therapy or for chronic pain in the absence of guideline support. Therefore, this request is not medically necessary.

Surgery, as per neurosurgeon: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back (Lumbar & Thoracic) (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307.

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. Guideline criteria have not been met. This injured worker presents with persistent low back and leg pain. Clinical exam findings are not correlated with imaging evidence of plausible nerve root compression. There is no documentation of a focal neurologic deficit. Detailed evidence of a recent, reasonable and/or comprehensive non-operative treatment protocol trial and failure has been submitted. There is no specific procedure identified in the submitted records, which would allow for medical necessity to be established. Therefore, this request is not medically necessary.