

<b>Case Number:</b>	CM13-0002919		
<b>Date Assigned:</b>	06/06/2014	<b>Date of Injury:</b>	09/15/2011
<b>Decision Date:</b>	07/29/2014	<b>UR Denial Date:</b>	07/08/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/24/2013

### 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 Preventative Medicine; has a subspecialty in Occupational Medicine and is licensed to practice in Iowa. 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 patient is a 59-year-old employee with a date of injury of September 15, 2011. Medical records indicate that the patient is undergoing treatment for a torn meniscus of the left knee; rotator cuff tear, left shoulder and cervical and lumbar strain. Subjective complaints include left shoulder, lower back, left knee and neck pain. Objective findings include tender at paracervical spine; non-tender thoracic spine; tender on palpation of the lumbosacral spine and at the sacroiliac joints bilaterally; right and left hips have full motion; left knee tenderness at the mediolateral joint line; no ligament instability with decreased motion of the knee; right knee exam reveals tenderness at the mediolateral joint line and at patellofemoral motion, no instability with decreased range of motion. Right and left ankles have full motion. Right and left foot exam was normal. Sensation is intact. Right shoulder has full motion. Left shoulder reveals tenderness at greater tuberosity and biceps and pain on abduction and internal-external rotation with limited motion of shoulder. Right and left elbows have full motion. Right and left wrists and hands have full motion. Treatment has consisted of Lycra, Norco or Tramadol, Pantoprazole, Naprosyn, Genicin and Synthroid.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**A Psyche Evaluation:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain program Page(s): 30-34. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Chronic Pain Programs, Psychologic Evaluation.

**Decision rationale:** The California MTUS Guidelines does not directly address referral for a psychiatric evaluation but discusses a multi-disciplinary approach to pain. Guidelines state that the criteria for the general use of multidisciplinary pain management programs includes an (1) An adequate and thorough evaluation has been made, including baseline functional testing so follow-up with the same test can note functional improvement; (2) Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement; (3) The patient has a significant loss of ability to function independently resulting from the chronic pain; (4) The patient is not a candidate where surgery or other treatments would clearly be warranted (if a goal of treatment is to prevent or avoid controversial or optional surgery, a trial of 10 visits may be implemented to assess whether surgery may be avoided); (5) The patient exhibits motivation to change, and is willing to forgo secondary gains, including disability payments to effect this change; & (6) Negative predictors of success above have been addressed. The Official Disability Guidelines states that psychological evaluations are recommended for appropriately identified patients during treatment for chronic pain. Psychological intervention for chronic pain includes setting goals, determining appropriateness of treatment, conceptualizing a patient's pain beliefs and coping styles, assessing psychological and cognitive function, and addressing co-morbid mood disorders (such as depression, anxiety, panic disorder, and posttraumatic stress disorder). The treating physician has not provided detailed documentation of chronic pain treatment trials and failures, specific goals of those treatments, and the goal of the psychiatric evaluation. As such the request is not medically necessary.

**Acupuncture (two (2) times a week for four (4) weeks): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Acupuncture.

**Decision rationale:** The Acupuncture Medical Treatment Guidelines clearly state that acupuncture is used as an option when pain medication is reduced or not tolerated; it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. The medical documents did not provide detail regarding patient's increase or decrease in pain medication. Further, there was no evidence to support that this treatment would be utilized as an adjunct to physical rehabilitation or surgical intervention to hasten functional recovery. The Official Disability Guidelines do not recommend acupuncture for acute low back pain, but may want to consider a trial of acupuncture for acute low back pain if it would facilitate participation in active rehab efforts. The initial trial should be 3-4 visits over 2 weeks with evidence of objective functional improvement, total of up to 8-12 visits over 4-6 weeks. There is

no evidence provided that indicates the patient received acupuncture before or that the acupuncture sessions are being used as an adjunct to physical rehabilitation or surgical intervention. As such, the request is not medically necessary.

**Chiropractic/Physiotherapy (two (2) times a week for four (4) weeks): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-60.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines clearly state that chiropractic treatment for the low back is recommended as an option. For therapeutic care, there should be a trial of six visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. For elective /maintenance care is it not recommended as medically necessary. For recurrences/flare-ups there is a need to reevaluate treatment success, if a return to work is achieved then 1-2 visits every 4-6 months. Guidelines also state that one of the goals of any treatment plan should be to reduce the frequency of treatments to the point where maximum therapeutic benefit continues to be achieved while encouraging more active self-therapy, such as independent strengthening and range of motion exercises, and rehabilitative exercises. The treating physician has not provided evidence of objective and measurable functional improvement during or after a trial of therapeutic care to warrant approval, of which is necessary under the California MTUS guidelines. Nor has the treating physician has not documented active self-therapy. As such, the request is not medically necessary.

**A Pain Management Referral: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain program Page(s): 30-34. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Chronic Pain Programs.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines state that the criteria for the general use of multidisciplinary pain management programs include (1) An adequate and thorough evaluation has been made, including baseline functional testing so follow-up with the same test can note functional improvement; (2) Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement; (3) The patient has a significant loss of ability to function independently resulting from the chronic pain; (4) The patient is not a candidate where surgery or other treatments would clearly be warranted (if a goal of treatment is to prevent or avoid controversial or optional surgery, a trial of 10 visits may be implemented to assess whether surgery may be avoided); (5) The patient exhibits motivation to change, and is willing to forgo secondary gains, including disability payments to effect this change; & (6) Negative predictors of success above have been

addressed. The treating physician has not provided detailed documentation of chronic pain treatment trials and failures to meet all six guideline criteria for a chronic pain management program. The treating physician has not provided detailed documentation of chronic pain treatment trials and failures, specific goals of those treatments, and the goal of the pain management referral. As such the request is not medically necessary.

**An Orthopedic Referral:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177, 208-209, 289, 296.

**Decision rationale:** The ACOEM Practice Guidelines states for a shoulder injury a referral for surgical consultation may be indicated for patients who have red-flag conditions; activity limitation for more than four months, plus existence of a surgical lesion; failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs, plus existence of a surgical lesion; clear clinical and imaging evidence of a lesion that has been shown to benefit, in both the short and long term, from surgical repair. Guidelines states that for neck and upper back injuries the presence of a herniated cervical or upper thoracic disk on an imaging study, however, does not necessarily imply nerve root dysfunction. Studies of asymptomatic adults commonly demonstrate intervertebral disk herniations that apparently do not cause symptoms. A referral for surgical consultation is indicated for patients who have persistent, severe, and disabling shoulder or arm symptoms; activity limitation for more than one month or with extreme progression of symptoms; clear clinical, imaging, and electrophysiologic evidence, consistently indicating the same lesion that has been shown to benefit from surgical repair in both the short- and long-term; and unresolved radicular symptoms after receiving conservative treatment. The ACOEM Practice Guidelines state that concerning low back complaints assessing Red Flags and Indications for Immediate Referral Physical-examination evidence of severe neurologic compromise that correlates with the medical history and test results may indicate a need for immediate consultation. The examination may further reinforce or reduce suspicions of tumor, infection, fracture, or dislocation. A history of tumor, infection, abdominal aneurysm, or other related serious conditions, together with positive findings on examination, warrants further investigation or referral. A medical history that suggests pathology originating somewhere other than in the lumbosacral area may warrant examination of the knee, hip, abdomen, pelvis or other areas. The treating physician has not provided the specific goal of the orthopedic referral and has not provided documentation to meet the above ACOEM Practice Guidelines for referral to an orthopedic specialist for shoulder, neck, and/or low back complaints. As such, the request is not medically necessary.

**Urine Analysis Test for Toxicology:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids and Substance abuse Page(s): 74-96;108-109. Decision based on Non-MTUS Citation University of Michigan Health System Guidelines for Clinical Care: Managing Chronic Non-terminal Pain, Including Prescribing Controlled Substances (May 2009), pg 32 Established Patients Using a Controlled Substance.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines state that the use of a urine drug screening for illegal drugs should be considered before therapeutic trial of opioids are initiated. Additionally, Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control. Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion) would indicate need for urine drug screening. There is insufficient documentation provided to suggest issues of abuse, addiction, or poor pain control by the treating physician. The University of Michigan Health System Guidelines for Clinical Care: Managing Chronic Non-terminal Pain, Including Prescribing Controlled Substances (May 2009 recommends for stable patients without red flags; a twice yearly urine drug screening for all chronic non-malignant pain patients receiving opioids - once during January-June and another July-December. The patient has been on chronic opioid therapy. The treating physician has not indicated why a urine drug screen is necessary at this time and has provided no evidence of red flags. As such, the request is not medically necessary.

**Pantoprazole 20mg (#60, one (1) tablet twice a day): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), NSAIDs, GI symptoms & cardiovascular risk.

**Decision rationale:** According to the Chronic Pain Medical Treatment Guidelines in order to determine if the patient is at risk for gastrointestinal events: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). Also the patients at intermediate risk for gastrointestinal events and no cardiovascular disease if: (1) A non-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg omeprazole daily) or misoprostol (200 g four times daily) or (2) a Cox-2 selective agent. Long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture (adjusted odds ratio 1.44). The medical documents provided do not establish the patient as having documented GI bleeding/perforation/peptic ulcer or other GI risk factors as outlined in Guidelines. As such, the request is not medically necessary.

**Cyclobenzaprine 7.5mg (#90, one (1) tablet twice a day): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril), Medications for chronic pain Page(s): 41-42, 60-61. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: UpToDate, Flexeril.

**Decision rationale:** According to the Chronic Pain Medical Treatment Guidelines Cyclobenzaprine (Flexeril), is recommended as an option, using a short course of therapy. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. Treatment should be brief. Additionally, guidelines state that relief of pain with the use of medications is generally temporary, and measures of the lasting benefit from this modality should include evaluating the effect of pain relief in relationship to improvements in function and increased activity. Before prescribing any medication for pain, the following should occur: (1) determine the aim of use of the medication; (2) determine the potential benefits and adverse effects; (3) determine the patient's preference. Only one medication should be given at a time, and interventions that are active and passive should remain unchanged at the time of the medication change. A trial should be given for each individual medication. Analgesic medications should show effects within 1 to 3 days, and the analgesic effect of antidepressants should occur within 1 week. A record of pain and function with the medication should be recorded. UpToDate also recommends for Cyclobenzaprine, but no longer than 2-3 weeks and is for short-term (2-3 weeks) treatment of muscle spasm associated with acute, painful musculoskeletal conditions. The medical documentation provided does not establish the need for long term/chronic usage of, Cyclobenzaprine. As such, the request is not medically necessary.

**Topical Medication containing Tramadol (7%), Gabapentin (7%), Cyclobenzaprine (5%/) and Lidocaine (4%), (120gm, apply a thin layer to affected area twice daily): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Topical Analgesics.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines indicate that topical medications are largely experimental in use with few randomized controlled trials to determine efficacy or safety. These are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. In this case, the medical records provided do not endorse failure of trials of oral adjuvant analgesics such as antidepressants or anticonvulsants. It is also noted this particular formulation contains agents that are not recommended for topical use under guidelines, specifically Tramadol and Gabapentin. The guidelines also indicate that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. There is no evidence for use of antiepilepsy drugs as a topical product, nor is there evidence for efficacy and safety of topical Tramadol. Capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. As such the request is not medically necessary.

**Urine Analysis Test for Toxicology: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Flurbiprofen, Topical Analgesics Page(s): 41-42, 72, 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Muscle relaxant, Compound creams.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines state that there is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The Official Disability Guidelines recommends usage of topical analgesics as an option, but also further details primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Medical documents provided do not indicate concerns for neuropathic pain. While topical NSAIDs and capsaicin may be recommended under specific circumstances, the medical literature failed to support the topical use of menthol. As at least one of the active agents in the requested topical compound is not supported for topical use, therefore the ointment is not medically necessary.