

<b>Case Number:</b>	CM13-0025130		
<b>Date Assigned:</b>	11/20/2013	<b>Date of Injury:</b>	06/12/2000
<b>Decision Date:</b>	03/18/2014	<b>UR Denial Date:</b>	09/04/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/17/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain Management and is licensed to practice in California. 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 physician 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.

### 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 is a female patient with a date of injury of June 12, 2000. A utilization review determination dated September 4, 2013 recommends noncertification of bio freeze, Prilosec, Relafen, tramadol (modified for weaning), water therapy, Zanaflex (modified for weaning), and Zoloft (modified for weaning). A progress report dated November 13, 2013 includes subjective complaints identifying low back pain, neck pain, and right knee pain. The note indicates that the patient continues to work but is struggling. Tramadol has been helpful, Relafen has been helpful, she has only been taking about one of those each day. The note also indicates that the patient has been taking Prilosec and Zoloft which the patient states that she needs. The previous psych QME had accepted psych as part of her complaint. Current medications include tramadol, Relafen, Zanaflex, Prilosec, Zoloft, and a bio freeze gel. Objective findings identified tenderness to palpation of across the lumbar spine with painful range of motion with muscle spasm. Diagnoses include chronic low back pain, right lower extremity pain, right-sided neck pain with radiating symptoms to the right upper extremity, chronic right knee pain, and bilateral TMJ. The treatment plan indicates that the patient is not taking any narcotics, and recommends ongoing use of tramadol, omeprazole, and Zoloft. The note acknowledges that aquatic therapy and Relafen were denied. A note dated October 26, 2012 indicates that the patient was started on Motrin but had severe G.I. upset which was then controlled with Prilosec. An appeal letter dated April 11, 2013 indicates that the patient is currently on Motrin and Relafen which meets the criteria for Prilosec. A progress report dated May 29, 2013 indicates that the medications are significantly helpful.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective Biofreeze #3: Upheld**

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

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

**Decision rationale:** Regarding the request for Biofreeze, Wikipedia indicates that the ingredients of bio freeze include menthol, aloe, and numerous other constituents. Chronic Pain Medical Treatment Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Guidelines do not contain support for the topical use of menthol, aloe, or any other of the constituents of Biofreeze. Within the documentation available for review, there is no indication that the patient has neuropathic pain and is failed a trial of antidepressant and anticonvulsants. In the absence of clarity regarding the above issues, the currently requested Biofreeze is not medically necessary.

**Retrospective Prilosec 20mg #150: Overturned**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Proton Pump Inhibitors (PPIs).

**Decision rationale:** Regarding the request for omeprazole (Prilosec), California MTUS states that proton pump inhibitors are appropriate for the treatment of dyspepsia secondary to NSAID therapy or for patients at risk for gastrointestinal events with NSAID use. Within the documentation available for review, there is evidence that the patient has had severe gastrointestinal upset from the use of NSAIDs. Additionally, the requesting physician has identified that the patient was being prescribed two NSAIDs, which would significantly increase the risk of gastric/duodenal ulcers, or even gastric hemorrhage. As such, the currently requested retrospective prilosec is medically necessary.

**Retrospective Relafen 750mg #180: Overturned**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-69.

**Decision rationale:** Regarding the request for Relafen (nabumetone), Chronic Pain Medical Treatment Guidelines state that NSAIDs are recommended at the lowest dose for the shortest

period in patients with moderate to severe pain. Within the documentation available for review, it is clear the patient has significant pain. The requesting physician has identified that the current pain medications improve the patient's pain and function (although, admittedly that documentation is rather non-specific). There have been some side effects noted from the use of NSAIDs, but those have reportedly been controlled with a proton pump inhibitor medication. As such, the currently requested retrospective Relafen is medically necessary. However, it should be noted that the concurrent use of 2 NSAIDs significantly increases the risk of G.I. complications.

**Retrospective Tramadol 50mg #100: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 75-79.

**Decision rationale:** Regarding the request for Ultram, California Pain Medical Treatment Guidelines state that Ultram is a short acting opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is no specific information indicating that the Ultram is improving the patient's function (in terms of specific objective functional improvement) or pain (in terms of reduced NRS or percent pain reduction), no documentation regarding side effects, and no discussion regarding aberrant use. In the absence of such documentation, the currently requested Ultram is not medically necessary.

**Water Therapy, 2 times per week for 4 weeks, for the right knee and low back: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chapter 13 Knee Complaints Page(s): 340, 298. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg Chapter, Aquatic Therapy, Low Back Chapter, Physical Therapy

**Decision rationale:** Regarding the request for aquatic therapy, Chronic Pain Treatment Guidelines state that aquatic therapy is recommended as an optional form of exercise therapy where available as an alternative to land-based physical therapy. They go on to state that it is specifically recommended whenever reduced weight bearing is desirable, for example extreme obesity. Guidelines go on to state that for the recommendation on the number of supervised visits, see physical therapy guidelines. Within the documentation available for review, there is no documentation indicating why the patient would require therapy in a reduced weight-bearing environment. Furthermore, there is no indication as to how many physical therapy sessions the patient has undergone and what specific objective functional improvement has been obtained

with the therapy sessions already provided. Finally, there is no statement indicating whether the patient is performing a home exercise program on a regular basis, and whether or not that home exercise program has been modified if it has been determined to be ineffective. In the absence of clarity regarding those issues, the currently requested aquatic therapy is not medically necessary.

**Retrospective Zanaflex 4mg #60: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66.

**Decision rationale:** Regarding the request for Zanaflex, Chronic Pain Medical Treatment Guidelines support the use of nonsedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Guidelines go on to state that Zanaflex specifically is FDA approved for management of spasticity; unlabeled use for low back pain. Within the documentation available for review, there is no identification of a specific analgesic benefit or objective functional improvement as a result of the Zanaflex. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. In the absence of such documentation, the currently requested Zanaflex is not medically necessary.

**Retrospective Zoloft 50mg #90: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Page(s): 395-396, 402 , 107.

**Decision rationale:** Regarding the request for Zoloft, Chronic Pain Medical Treatment Guidelines state that selective serotonin reuptake inhibitors may have a role in treating secondary depression. Additionally, guidelines recommend follow-up evaluation with mental status examinations to identify whether depression is still present. Guidelines indicate that a lack of response to antidepressant medications may indicate other underlying issues. Within the documentation available for review, there is no evidence of any recent subjective complaints of depressive symptoms or a recent mental status examination to determine a diagnosis of depression. Additionally, there is no documentation indicating whether or not the patient has responded to the current Zoloft treatment and no discussion regarding side effects. In the absence of clarity regarding those issues, the currently requested Zoloft is not medically necessary.