

Case Number:	CM13-0039418		
Date Assigned:	12/18/2013	Date of Injury:	03/06/2013
Decision Date:	02/25/2014	UR Denial Date:	10/01/2013
Priority:	Standard	Application Received:	10/28/2013

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 Neurology, has a subspecialty in Neuromuscular Medicine 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. 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:

██████████ is a 56-year-old woman who sustained a work-related injury on March 6, 2013. Subsequently the patient developed but chronic pain in both upper and lower extremities as well as back and neck pain. According to the notes of ██████████ dated on July 27, 2013, the patient reported to 8-9/10 sharp pain in both upper and lower extremities with weakness. The patient reported numbness and stiffness is aggravated by exercise, prolonged weight-bearing, sitting standing and walking. Her EMG nerve conduction studies performed on May 2, 2013 were normal. Physical examination demonstrated painful decrease in cervical range of motion. The patient was diagnosed with the cervical strain, cervical radiculopathy, lumbar strain, lumbar radiculopathy myalgia, headaches, anxiety and stress. The patient was treated with Naprosyn, Medrox patches, omeprazole, Xanax, and Percocet, home exercise, luxation techniques and aquatic rehabilitation.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 refill of Medrox ointment.: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics. Page(s): 111.

Decision rationale: According to MTUS, in Chronic Pain Medical Treatment guidelines section Topical Analgesics (page 111), topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Many agents are combined to other pain medications for pain control. There is limited research to support the use of many of these agents. Furthermore, according to MTUS guidelines, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. There is no documentation of failure of oral form of one or all compound of the patch. (menthol, capsaicin, methyl salicylate). In addition there is no evidence of to support efficacy of each of the component of Medrox for the treatment of spinal conditions. Therefore, topical analgesic Medrox patch (menthol, capsaicin, methyl salicylate) is not medically necessary.

1 refill of Omeprazole 20 mg.: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk. Page(s): 102.

Decision rationale: According to MTUS guidelines, Omeprazole is indicated when NSAID are used in patients with intermediate or high risk for gastrointestinal events . The risk for gastrointestinal events are: (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). Recent studies tend to show that [REDACTED] does not act synergistically with NSAIDS to develop gastroduodenal lesions. There is no documentation in the patient's chart supporting that she is at intermediate or high risk for developing gastrointestinal events. Therefore, Omeprazole 20 mg prescription is not medically necessary.

1 request to continue home exercise and aquatic rehab.: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic therapy. Page(s): 22.

Decision rationale: According to MTUS guidelines, aquatic therapy is recommended as an optional form of exercise therapy, where available, as an alternative to land based physical therapy. Aquatic therapy (including swimming) can minimize the effects of gravity, so it is specifically recommended where reduced weight bearing is desirable, for example extreme obesity. For recommendations on the number of supervised visits, see Physical medicine. Water exercise improved some components of health-related quality of life, balance, and stair climbing in females with fibromyalgia, but regular exercise and higher intensities maybe required to preserve most of these gains. (Tomas-Carus, 2007). There no clear evidence that the patient is

obese or has difficulty performing land based physical therapy or there is a need for the reduction of weight bearing to improve the patient's ability to perform particular exercise regimen. There is no clear objective documentation for the need of aquatic therapy. Therefore aquatic therapy is not medically necessary. More justification is needed.

Trigger point injections to cervical and lumbar spine.: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger point injections Page(s): 122.

Decision rationale: According to MTUS guidelines, trigger point injections are recommended only for myofascial pain syndrome as indicated below, with limited lasting value. They are not recommended for radicular pain. Trigger point injections with an anesthetic such as bupivacaine are recommended for non-resolving trigger points, but the addition of a corticosteroid is not generally recommended. A trigger point is a discrete focal tenderness located in a palpable taut band of skeletal muscle, which produces a local twitch in response to stimulus to the band. Trigger points may be present in up to 33-50% of the adult population. Myofascial pain syndrome is a regional painful muscle condition with a direct relationship between a specific trigger point and its associated pain region. These injections may occasionally be necessary to maintain function in those with myofascial problems when myofascial trigger points are present on examination. Not recommended for typical back pain or neck pain. (Graff-Radford, 2004) (Nelemans-Cochrane, 2002) For fibromyalgia syndrome, trigger point injections have not been proven effective. (Goldenberg, 2004). Trigger point injections with a local anesthetic may be recommended for the treatment of chronic low back or neck pain with myofascial pain syndrome when all of the following criteria are met: (1) Documentation of circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain; (2) Symptoms have persisted for more than three months; (3) Medical management therapies such as ongoing stretching exercises, physical therapy, NSAIDs and muscle relaxants have failed to control pain; (4) Radiculopathy is not present (by exam, imaging, or neuro-testing); (5) Not more than 3-4 injections per session; (6) No repeat injections unless a greater than 50% pain relief is obtained for six weeks after an injection and there is documented evidence of functional improvement; (7) Frequency should not be at an interval less than two months; (8) Trigger point injections with any substance (e.g., saline or glucose) other than local anesthetic with or without steroid are not recommended. There is no clear evidence of myofascial pain or failure of oral medications in this case. Therefore, the request for trigger point injections to cervical and lumbar spine is not medically necessary