

Case Number:	CM13-0067347		
Date Assigned:	01/03/2014	Date of Injury:	06/01/2007
Decision Date:	07/03/2014	UR Denial Date:	11/18/2013
Priority:	Standard	Application Received:	12/17/2013

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 Physical Medicine and Rehabilitation and is licensed to practice in Illinois. 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:

The injured worker is a 49-year-old female with a reported date of injury on 06/01/2007. The injured worker presented with neck pain, bilateral upper extremity pain, and low back pain. According to the clinical information provided, the injured worker had a permanent spinal cord stimulator implanted on 01/23/2013. The injured worker reported a 66.7% relief of her lower extremity and back pain following implantation of the permanent spinal cord stimulator. The injured worker rated her neck pain as 9/10. According to the clinical note dated 10/30/2013, the injured worker was active in a home based exercise program. The physician noted that the injured worker's activities were mainly limited by neck and upper extremity pain. The injured worker's range of motion values were not provided within the documentation available for review. According to the documentation provided, the injured worker's diagnoses included chronic pain syndrome, knee pain, pain in the shoulder joint, facet syndrome, carpal tunnel syndrome bilaterally, post lumbar laminectomy, post cervical laminectomy, and myofascial pain syndrome. The injured worker's medication regimen included Novolin 70/30, Flonase, K-Tabs, Glucophage, ibuprofen, Levothroid, Prilosec, Imitrex 50 mg, aspirin, Opana ER 20 mg, Opana ER 10 mg, Opana 10 mg, Cymbalta, Lidoderm patches, Senna, Trazodone, Voltaren transdermal gel, Flexeril, Lisinopril and Gralise. The request for authorization for Flexeril 10 mg #60, Voltaren gel 2-4 inches to affected area 4x/day quantity 5 tubes, Lidoderm patch #90, eight aqua therapy visits, and twelve acupuncture visits was submitted on 12/17/2013. According to the document dated 10/30/2013, the rationale for acupuncture was stated to decrease neck and upper extremity pain, increase function and range of motion, and decrease opiate and medication use. In addition, the physician requested a trial of acupuncture and aqua therapy prior to possible placement of second spinal cord stimulator.

IMR ISSUES, DECISIONS AND RATIONALES

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

FLEXERIL 10MG #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Page(s): 41.

Decision rationale: According to the California MTUS Guidelines, Flexeril is recommended as an option, using a short course of therapy. The effect of Flexeril is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. According to the clinical documentation provided, for review the injured worker has been utilizing Flexeril prior to 04/25/2013. Therefore, the request for continued use of Flexeril would exceed the recommended guidelines. In addition, there is a lack of objective clinical findings of therapeutic effectiveness of the Flexeril and the request as submitted failed to provide frequency and directions for use. Therefore, the request for Flexeril 10 mg #60 is non-certified.

VOLTAREN GEL 2-4 INCHES TO AFFECTED AREA 4X/DAY QTY: 5 TUBES: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

Decision rationale: The California MTUS Guidelines recommend topical analgesics as an option. Topical Analgesics are largely experimental and used with few randomized control trials to determine effectiveness or safety. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. In addition, topical NSAIDs are recommended for short term use (4 to 12 weeks). There is little evidence to utilize topical NSAIDs for osteoarthritis of the spine, hip, or shoulder. Voltaren gel 1% is indicated for relief of osteoarthritis pain and joints that lend themselves to topical treatment to include ankle, elbow, foot, hand, knee, and wrist. Voltaren has not been evaluated for treatment of the spine, hip, or shoulder. According to the clinical documentation provided for review, the injured worker has been utilizing Voltaren cream prior to 04/25/2013. There is a lack of documentation related to the therapeutic benefits of the continued use of Voltaren. In addition, the request as submitted failed to provide the frequency, site to be used, and percentage of diclofenac that is in the Voltaren gel requested. Therefore, the request for Voltaren gel is non-certified.

LIDODERM PATCH #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm Page(s): 56.

Decision rationale: The California MTUS guidelines state that Lidoderm is a brand name for a lidocaine patch. Topical lidocaine may be recommended for localized peripheral pain after there has been evidence of trials of first line therapy to include antidepressants or antiepileptics, such as gabapentin or Lyrica. Lidoderm is not a first line treatment and is only FDA approved for postherpetic neuralgia. Further research is needed to recommended the treatment for chronic neuropathic pain disorders other than postherpetic neuralgia. According to the clinical documentation provided for review, the injured worker has utilized Lidoderm prior to 04/25/2013. There is a lack of documentation related to the therapeutic benefit related to prior use of Lidoderm. In addition, the injured worker does not have a diagnosis of postherpetic neuralgia. The guidelines state that further research is needed to recommended this treatment for chronic neuropathic pain disorders other than postherpetic neuralgia. In addition, the request as submitted failed to provide a frequency and specified site at which the Lidoderm was to be utilized. Therefore, the request for Lidoderm patch #90 is non-certified.

EIGHT AQUA THERAPY VISITS: Upheld

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

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

Decision rationale: The California MTUS Guidelines recommend aquatic therapy as an optional form of exercise therapy where available, as an alternative to the land based physical therapy. Aquatic therapy can minimize the effects of gravity so it is specifically recommended where reduced weight bearing is desirable. The guidelines recommend 8 to 10 visits over a 4 week period. According to the clinical note dated 10/30/2013, the injured worker was participating in a home based exercise program. The rationale for the request is not provided within the documentation available for review. The injured worker's complaints are in the neck and upper extremities. In addition, the request as submitted failed to provide goals and outcomes for the request for aqua therapy. In addition, the request as submitted failed to provide the specific functional deficit the aqua therapy will be addressing. Therefore, the request for 8 aqua therapy visits is non-certified.

TWELVE ACUPUNCTURE VISITS: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: According to the California MTUS Guidelines, acupuncture is used an option when pain medication is not tolerated, may be used as an addition to physical rehabilitation. Acupuncture can be used to reduce pain, reduce inflammation, increase blood flow, increase range of motion, decrease side effects of medication induced nausea, promote relaxation in the anxious patient, and reduce muscle spasm. According to the guidelines, the time to produce functional improvement would be 3 to 6 treatments with an optimum duration of 1 to 2 months. The rationale for the request of acupuncture was to decrease neck and upper extremity pain, increase function/range of motion, and decrease opioid medication use. There is a lack of documentation as to the injured workers functional deficits, to include range of motion values. In addition, the request for 12 acupuncture visits exceeds the recommended guidelines. Therefore, the request for 12 acupuncture visits is non-certified.