

<b>Case Number:</b>	CM13-0071383		
<b>Date Assigned:</b>	01/08/2014	<b>Date of Injury:</b>	01/15/2007
<b>Decision Date:</b>	12/09/2014	<b>UR Denial Date:</b>	12/06/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/27/2013

### 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, 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 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 is a female patient with the date of injury of January 15, 2007. A Utilization Review was performed on December 6, 2013 and recommended non-certification of pain psychology 4-6 visits, repeat right lumbar radiofrequency treatment, bilateral thoracic epidural steroid blocks, Ambien CR 6.25mg #20 x 5 refills, MS Contin 30mg #60, and Cyclo/Gaba cream 10%/10% 1 tub and modification of physical therapy 6 sessions to 3 sessions. An Industrial Recheck Report dated November 18, 2013 identifies history of present illness of 8/10 pain still in the mid back, low back, and down into the left lower extremity. Examination identifies pain on lumbar extension more so than flexion in the low back, felt more to that left side. Some probable spasm over the lumbar paraspinals. Still antalgic for gait a bit on the left, Spring testing causing some groin and buttock pain. Diagnoses identify low back pain, lumbar and sacral osteoarthritis, thoracic spine pain without radiculopathy, discitis of thoracic region, facet syndrome, bilateral inguinal hernia without mention of obstruction or gangrene, sacroiliac joint pain, hip pain, iliopsoas tendinitis, and trochanteric bursitis. Medications/Treatment Plan identifies refill Ambien, MS Contin, Cyclogaba cream, add Ambien in place of Ambien CR.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Pain psychology 4-6 visits:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 100-102. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chronic Pain, Behavioral Interventions

**Decision rationale:** Regarding the request for pain psychology 4-6 visits, Chronic Pain Medical Treatment Guidelines state that psychological evaluations are recommended. Psychological evaluations are generally accepted, well-established diagnostic procedures not only with selected using pain problems, but also with more widespread use in chronic pain populations. Diagnostic evaluations should distinguish between conditions that are pre-existing, aggravated by the current injury, or work related. Psychosocial evaluations should determine if further psychosocial interventions are indicated. ODG states the behavioral interventions are recommended. Guidelines go on to state that an initial trial of 3 to 4 psychotherapy visits over 2 weeks may be indicated. With evidence of objective functional improvement, a total of up to 6 to 10 visits over 5 to 6 weeks may be required. Within the documentation available for review, the patient is noted to have chronic pain. However, the request exceeds guidelines for an initial trial, and unfortunately, there is no provision in place to modify the request. As such, the current request for pain psychology 4-6 visits is not medically necessary.

**6 sessions of physical therapy:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): table 12-5. Decision based on Non-MTUS Citation Official Disability Guidelines, Physical therapy guidelines

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**Decision rationale:** Regarding the request for 6 sessions of physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, there is no indication of any specific objective treatment goals and no statement indicating why an independent program of home exercise would be insufficient to address any objective deficits. In the absence of such documentation, the current request for 6 sessions of physical therapy is not medically necessary.

**Repeat right lumbar radiofrequency treatment:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Treatment in Workers' Compensation ([http://www.odg-twc.com/odgtwc/low\\_back.htm](http://www.odg-twc.com/odgtwc/low_back.htm)), Lumbar rhizotomy

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Low Back, 9792.20 Page(s): 300, 309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Facet Joint Pain, Signs & Symptoms, Facet Joint Diagnostic Blocks (Injections), Facet Joint Radiofrequency Neurotomy

**Decision rationale:** Regarding the request for repeat right lumbar radiofrequency treatment, Chronic Pain Medical Treatment Guidelines state lumbar facet neurotomies reportedly produce mixed results. Facet neurotomies should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks. ODG states while repeat neurotomies may be required, they should not occur at an interval of less than 6 months from the first procedure. A neurotomy should not be repeated unless duration of relief from the first procedure is documented for at least 12 weeks at 50% relief. The current literature does not support that the procedure is successful without sustained pain relief (generally of at least 6 months duration). No more than 3 procedures should be performed in a year's period. Within the medical information made available for review, there is no documentation that at least 6 months have passed since the prior procedure and that there was 50% relief after the previous neurotomy. In the absence of such documentation, the currently requested repeat right lumbar radiofrequency treatment is not medically necessary.

**Bilateral thoracic epidural steroid blocks:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46.

**Decision rationale:** Regarding the request for bilateral thoracic epidural steroid blocks, California MTUS cites that ESI is recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy) and radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Within the documentation available for review, there is no documentation of radicular pain and radiculopathy documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. In the absence of such documentation, the current request for bilateral thoracic epidural steroid blocks is not medically necessary.

**Ambien CR 6.25mg #20 with 5 refills:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Treatment in Workers' Compensation (<http://www.odg-twc.com/odgtwc/pain.htm>), Insomnia

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) Chronic Pain, Sleep Medication, Insomnia treatment

**Decision rationale:** Regarding the request for Ambien, California MTUS guidelines are silent regarding the use of sedative hypnotic agents. ODG recommends the short-term use (usually two to six weeks) of pharmacological agents only after careful evaluation of potential causes of sleep disturbance. They go on to state the failure of sleep disturbances to resolve in 7 to 10 days, may indicate a psychiatric or medical illness. Within the documentation available for review, there are no subjective complaints of insomnia, no discussion regarding how frequently the insomnia complaints occur or how long they have been occurring, no statement indicating what behavioral treatments have been attempted for the condition of insomnia, and no statement indicating how the patient has responded to Ambien treatment. Finally, there is no indication that Ambien is being used for short term use as recommended by guidelines. In the absence of such documentation, the currently requested Ambien is not medically necessary.

**MS Contin 30mg #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 44, 47, 75-79, 120.

**Decision rationale:** Regarding the request for MS Contin, California Pain Medical Treatment Guidelines state that MS Contin is an 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 indication that the medication is improving the patient's function or pain (in terms of specific examples of functional improvement and percent reduction in pain or reduced NRS), no documentation regarding side effects, and no discussion regarding aberrant use. As such, there is no clear indication for ongoing use of the medication. Opioids should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In light of the above issues, the currently requested MS Contin is not medically necessary.

**Cyclo/Gaba cream 10% / 10% 1 tub:** Upheld

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

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

**Decision rationale:** Regarding the request for Cyclo/Gaba cream, Cyclo/Gaba cream is a combination of cyclobenzaprine and gabapentin. Chronic Pain Medical Treatment Guidelines state that any compounded product that contains at least one drug or drug class that is not recommended is not recommended. Chronic Pain Medical Treatment Guidelines state that

topical muscle relaxants are not recommended. They go on to state that there is no evidence for the use of any muscle relaxants as a topical product. In addition, Chronic Pain Medical Treatment Guidelines state that topical gabapentin is not recommended and that there is no peer-reviewed literature to support its use. As such, the currently requested Cyclo/Gaba cream is not medically necessary.