

Case Number:	CM14-0002630		
Date Assigned:	01/29/2014	Date of Injury:	09/20/2013
Decision Date:	06/13/2014	UR Denial Date:	01/03/2014
Priority:	Standard	Application Received:	01/03/2014

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 Therapy 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 patient with a date of injury of September 20, 2013. A utilization review determination dated February 3, 2014 recommends non-certification of electrodiagnostic studies in bilateral upper and lower extremities, cyclobenzaprine, tramadol ER, Terocin lotion, physical therapy, trigger point injections in the lower back, TENS (transcutaneous electrical nerve stimulation) unit, and urine toxicology screen. A progress report dated October 21, 2013 identifies that the patient has been granted physical therapy and has made appointments for therapy visits. The note indicates that the anti-inflammatory medication and muscle relaxant have been providing comfort for him and allow him to function better. He is using pain medication only as necessary. Physical examination findings revealed tenderness to palpation in the lumbar spine. Diagnoses include low back strain and x-ray diagnosis of moderate L5-S1 intervertebral disc degeneration. The treatment plan recommends continuing physical therapy, refill Norflex, refill diclofenac, and advise the patient on appropriate medication use. A progress report dated December 16, 2013 identifies subjective complaints of low back pain which radiates down his right leg to his calf. The patient is noted to use medications when going to sleep which helped him relax and feel better when stretching. Current medications include Norflex, Voltaren, hydrocodone, and aspirin. Physical examination findings reveal restricted lumbar range of motion with normal motor strength and decreased sensation in the L4-L5 and L5-S1 distribution on the right. Reduced reflexes are also present in the gastro/soleus muscle group. Straight leg raising his positive on the right. A review of imaging identifies an MRI performed on December 9, 2013 identifying a posterior annular fissure at L4-L5 and slight retro list thesis of L3 on L4. Diagnoses include lumbosacral spondylosis L4-L5 and L5-S1 with the set arthropathy and right-sided S I joint inflammation. The treatment plan recommends physical therapy, lumbar support brace, tens unit, EMG/NCV's to rule out compressive neuropathy versus radiculopathy (due to numbness

and tingling in bilateral lower extremities), trigger point injections due to "trigger point pain over the right iliac crest and over the right lumbosacral area", and urine toxicology screen. Terocin, flexmid, and Ultracet are also recommended.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCV BUE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 238.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck Chapter, Electrodiagnostic Studies, Electromyography, Nerve Conduction Studies

Decision rationale: Regarding the request for EMG/NCV of bilateral upper extremities, Occupational Medicine Practice Guidelines state that the electromyography and nerve conduction velocities including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. Within the documentation available for review, there are no recent subjective complaints or physical examination findings identifying subtle focal neurologic deficits in the upper extremities, for which the use of electrodiagnostic testing would be indicated. The request for an EMG/NCV of the BUE is not medically necessary or appropriate.

EMG/NCV BILATERAL BLE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 238.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178,182. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Electrodiagnostic Studies.

Decision rationale: Regarding the request for EMG/NCV of the lower extremities, Occupational Medicine Practice Guidelines state that unequivocal objective findings that identify specific nerve compromise on the neurologic exam are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery. When a neurologic examination is less clear however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. They go on to state that electromyography may be useful to identify subtle focal neurologic dysfunction in patients with low back symptoms lasting more than three to four weeks. ODG states that nerve conduction studies are not recommended for back conditions. They go on to state that there is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. Within the documentation available for review, the requesting physician has identified unequivocal objective findings that identify specific nerve compromise. Additionally, an MRI

has already been performed identifying pathology at the expected levels. Therefore, it is unclear how the currently requested electrodiagnostic testing will affect the current medical decision-making. Finally, it is unclear that the patient has completed all reasonable conservative care prior to the currently requested interventional diagnostic study. The request for an EMG/NCV of the BLE is not medically necessary or appropriate.

4-4-2 TRIGGER POINT INJECTION TO THE LOWER BACK: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger Point Injections Page(s): 122.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 122. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chronic Pain Chapter, Trigger Point Injections.

Decision rationale: < Regarding the request for trigger point injections, Chronic Pain Medical Treatment Guidelines support the use of trigger point injections after three months of conservative treatment provided trigger points are present on physical examination. ODG states that repeat trigger point injections may be indicated provided there is at least 50% pain relief with reduction in medication use and objective functional improvement for 6 weeks. Within the documentation available for review, there are no physical examination findings consistent with trigger points, such as a twitch response as well as referred pain upon palpation. Additionally, there is no documentation of failed conservative treatment for three months. The request for 4-4-2 trigger point injection to the lower back is not medically necessary or appropriate.

URINE TOXICOLOGY SCREEN: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines URINE TOXICOLOGY SCREENS Page(s): 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 76-79,99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chronic Pain Chapter, Urine Drug Testing Section.

Decision rationale: Regarding the request for a urine toxicology test, the Chronic Pain Medical Treatment Guidelines state the drug testing is recommended as an option. Guidelines go on to recommend monitoring for the occurrence of any potentially aberrant (or non-adherent) drug related behaviors. ODG recommends urine drug testing on a yearly basis for low risk patients, two to three times a year for moderate risk patients, and possibly once per month for high risk patients. Within the documentation available for review, the provider notes that the patient has been prescribed opiate pain medication. The request for a urine toxicology screen is medically necessary and appropriate.

CYCLOBENZAPRINE 7.5MG #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (For Pain) Page(s): 63.

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

Decision rationale: Regarding the request for cyclobenzaprine (Flexeril), Chronic Pain Medical Treatment Guidelines support the use of non-sedating 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 cyclobenzaprine specifically is recommended for a short course of therapy. Within the documentation available for review, there is no identification of a specific analgesic benefit or objective functional improvement as a result of the cyclobenzaprine. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. The request for Cyclobenzaprine 7.5 mg, ninety count, is not medically necessary or appropriate.

TRAMADOL ER(ULTRAM ER) 150MG #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids - Tramadol (Ultram) Page(s): 79-81.

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, it is unclear whether Ultram ER is a new prescription or has been prescribed previously. If it has been prescribed previously, there is no documentation of improved function (in terms of specific objective functional improvement) or pain (in terms of reduced NRS or percent reduction in pain), no documentation regarding side effects, and no discussion regarding aberrant use. If this is a new prescription, there is no documentation regarding the risks and benefit of this medication, the proposed functional treatment goals to be obtained with the use of this medication, or any attempt at risk stratification prior to determining whether opiate pain medication is an appropriate option for this patient. The request for Tramadol ER (Ultram ER) 150 mg, thirty count, is not medically necessary or appropriate.

TEROCIN LOTION #240: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

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

Decision rationale: Regarding the request for Terocin, Terocin is a combination of methyl salicylate, menthol, lidocaine and capsaicin. 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. Regarding the use of topical nonsteroidal anti-inflammatory, guidelines state that the efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs (non-steroidal anti-inflammatory drugs) have been shown in meta-analysis to be superior to placebo during the first two weeks of treatment osteoarthritis, but either not afterwards, or with the diminishing effect over another two-week period. Regarding use of capsaicin, guidelines state that it is recommended only as an option for patients who did not respond to or are intolerant to other treatments. Regarding the use of topical lidocaine, guidelines the state that it is recommended for localized peripheral pain after there is evidence of a trial of first-line therapy. Within the documentation available for review, there is no indication that the patient is unable to tolerate oral NSAIDs. Oral NSAIDs have significantly more guideline support compared with topical NSAIDs. Additionally, there is no indication that the topical NSAID is going to be used for short duration. Additionally, there is no documentation of localized peripheral pain with evidence of failure of first-line therapy as recommended by guidelines prior to the initiation of topical lidocaine. Finally, there is no indication that the patient has been intolerant to or did not respond to other treatments prior to the initiation of capsaicin therapy. The request for Terocin lotion #240 is not medically necessary or appropriate.

TENS UNIT: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS - Transcutaneous Electrotherapy Page(s): 114-116.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-117.

Decision rationale: Regarding the request for TENS, Chronic Pain Medical Treatment Guidelines state that transcutaneous electrical nerve stimulation (TENS) unit is not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option if used as an adjunct to a program of evidence-based functional restoration. Guidelines recommend failure of other appropriate pain modalities including medications prior to a TENS unit trial. Prior to TENS unit purchase, one month trial should be documented as an adjunct to ongoing treatment modalities within a functional restoration approach, with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function. Within the documentation available for review, there is no indication that the patient has undergone a TENS unit trial, and no documentation of any specific objective functional deficits which a tens unit trial would be intended to address. The request for a TENS unit is not medically necessary or appropriate.

PHYSICAL THERAPY 2X6 FOR LUMBAR SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy Section Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 298, Chronic Pain Treatment Guidelines Page(s): 98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Physical Therapy.

Decision rationale: Regarding the request for additional 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 objective functional improvement from the therapy already provided, no documentation of specific ongoing objective treatment goals, and no statement indicating why an independent program of home exercise would be insufficient to address any remaining objective deficits. The request for physical therapy for the lumbar spine, twice weekly for six weeks, is not medically necessary or appropriate.