

Case Number:	CM14-0121231		
Date Assigned:	09/16/2014	Date of Injury:	08/15/2011
Decision Date:	12/15/2014	UR Denial Date:	07/21/2014
Priority:	Standard	Application Received:	07/31/2014

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 Medicine and Rehabilitation and is licensed to practice in Texas. 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 patient is a 40 year old male who sustained an injury on 08/15/2011 when he was lifting iron rods and felt pain to his low back, inguinal area, and lower abdomen. Progress report dated 08/07/2014 documented the patient to have complaints of burning pain, radicular low back pain, and muscles spasms. He rated his pain as an 8/10. The pain also radiates into the hips, legs, and feet with numbness and tingling. He reported difficulty with sleeping and states the medications offer him temporary relief of pain and improves his ability to sleep. On exam, there is tenderness to palpation of the lumbar paraspinal muscles with trigger points noted. Range of motion of the lumbar spine revealed flexion to mid patella; extension to 07 degrees; lateral flexion to 10 degrees bilaterally; and right rotation to 07 degrees. He is diagnosed with lumbago, lumbar spine disc displacement, grade 3 spondylolisthesis of L5 of the lumbar region; spinal stenosis of the lumbar region; lumbar radiculopathy, status post bilateral inguinal hernia repair and sleep disorder. He was recommended medications listed below. Prior utilization review dated 07/21/2014 states the requests for Deprizine strength and quantity unknown; Fanatrex strength and quantity unknown; Synapryn strength and quantity unknown; Tabradol strength and quantity unknown; Capsaicin strength and quantity unknown; Flurbiprofen strength and quantity unknown; Cyclobenzaprine strength and quantity unknown; Menthol strength and quantity unknown; Terocin Patches strength and quantity unknown; Localized Intense Neurostimulation Therapy, one (1) time per week for six (6) weeks for the lumbar spine; Physical Therapy three (3) times per week for six (6) weeks for the lumbar spine; Acupuncture three (3) times per week for six (6) weeks for the lumbar spine; Chiropractic manipulation three (3) times per week for six (6) weeks for the lumbar spine; and Shockwave Therapy six (6) treatments for the lumbar spine are denied as medical necessity has not been established.

IMR ISSUES, DECISIONS AND RATIONALES

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

Deprizine strength and quantity unknown: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69.

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines notes that PPI are indicated for patients with intermediate or high risk for GI events. There is an absence in documentation noting that this claimant has secondary GI effects due to the use of medications or that he is at an intermediate or high risk for GI events. Deprizine is not a PPI, first line of treatment but an H2 receptor agonist. Additionally, non-specific strength and quantity is not supported. Therefore, this request is not medically necessary.

Fanatrex strength and quantity unknown: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy Drugs Page(s): 16-18.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy Drugs Page(s): 18-19.

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines as well as Official Disability Guidelines reflect that anti-epileptics are recommended for neuropathic pain. There is an absence in documentation noting that this claimant has objective findings of neuropathy. Additionally, non-specific strength and quantity is not supported. Therefore, this request is not medically necessary.

Synapryn strength and quantity unknown: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Glucosamine, Opioids, Topical Analgesics Page(s): 50, 75, 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment Index, 12th Edition (web), 2014, Pain-Medical food

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-97.

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines reflect that Tramadol (Ultram) is a centrally acting synthetic opioid analgesic and it is not recommended as a first-line oral analgesic. There is an absence in documentation noting the claimant has failed first

line of treatment or that he requires opioids at this juncture. Additionally, non-specific strength and quantity is not supported. Therefore, this request is not medically necessary.

Tabradol strength and quantity unknown: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Topical Analgesics Page(s): 75, 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment Index, 12th Edition (web), 2014, Pain-Medical food; National Institutes Of Health (NIH), National Library Of Medicine (NLM), PubMed, 2014 (www.ncbi.nlm.nih.gov/pubmed/)

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

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines as well as Official Disability Guidelines does not support the long term use of muscle relaxants. There are no extenuating circumstances to support the long term use of this medication in this case. Additionally, non-specific strength and quantity is not supported. Therefore, this request is not medically necessary.

Capsaicin strength and quantity unknown: 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 Topical Analgesics Page(s): 111-113.

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines as well as Official Disability Guidelines reflect that these medications 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. There is an absence in documentation noting that this claimant cannot tolerate oral medications or that he has failed first line of treatment. Additionally, non-specific strength and quantity is not supported. Therefore, this request is not medically necessary.

Flurbiprofen strength and quantity unknown: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113. Decision based on Non-MTUS Citation U.S. National Institutes of Health (NIH), National Library Of Medicine (NLM), PubMed, 2014 (www.ncbi.nlm.nih.gov/pubmed/)

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

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines as well as Official Disability Guidelines reflect that these medications 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. There is an absence in documentation noting that this claimant cannot tolerate oral medications or that he has failed first line of treatment. Additionally, non-specific strength and quantity is not supported. Therefore, this request is not medically necessary.

Menthol strength and quantity unknown: 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 Topical Analgesics Page(s): 111-113.

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines as well as Official Disability Guidelines reflect that these medications 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. There is an absence in documentation noting that this claimant cannot tolerate oral medications or that he has failed first line of treatment. Additionally, non-specific strength and quantity is not supported. Therefore, this request is not medically necessary.

Cyclobenzaprine strength and quantity unknown: 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 Cyclobenzaprine (Flexeril) Page(s): 41, 64.

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines does not support the long-term use of muscle relaxants. There are no extenuating circumstances to support the long term use of this medication in this case. Additionally, non-specific strength and quantity is not supported. Therefore, this request is not medically necessary.

Terocin Patches strength and quantity unknown: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Salicylate, Topical Analgesics Page(s): 115, 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 12th Edition (web), 2014, Chronic pain-Salicylate topicals

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

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines reflect that these medications 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. There is an absence in documentation noting that this claimant cannot tolerate oral medications or that he has failed first line of treatment. Additionally, nonspecific strength and quantity is not supported. Therefore, this request is not medically necessary.

Localized Intense Neurostimulation Therapy, one (1) time per week for six (6) weeks for the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines notes that Interferential unit is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. There is an absence in documentation noting that this claimant has had a trial with daily pain diaries noting functional and documented improvement. Therefore, this request is not medically necessary.

Physical Therapy three (3) times per week for six (6) weeks for the lumbar spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Physical Therapy

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines as well as Official Disability Guidelines notes that one should allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. There is an absence in documentation noting that this claimant cannot perform a home exercise program. There are no extenuating circumstances to support physical therapy at this juncture. Therefore, this request is not medically necessary.

Acupuncture three (3) times per week for six (6) weeks for the lumbar spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Acupuncture

Decision rationale: Official Disability Guidelines stress the importance of a time-limited treatment plan with clearly defined functional goals, with frequent assessment and modification of the treatment plan based upon the patient's progress in meeting those goals, and monitoring from the treating physician is paramount. In addition, Acupuncture Medical Treatment Guidelines state that acupuncture may be used as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Furthermore, guidelines state that time to produce functional improvement of 3 - 6 treatments. Therefore, this request is not medically necessary.

Chiropractic manipulation three (3) times per week for six (6) weeks for the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Page(s): 58-59. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Manual Therapy & Manipulation

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines as well as Official Disability Guidelines notes that manual therapy and manipulation is recommended for chronic pain if caused by musculoskeletal conditions. The guidelines state, "Low back: Recommended as an option. Therapeutic care - Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. Elective/maintenance care - Not medically necessary. Recurrences/flare-ups - Need to re-evaluate treatment success, if return to work (RTW) achieved then 1-2 visits every 4-6 months. Time to produce effect: 4 to 6 treatments." Based on the records provided, there is an absence in documentation noting that this claimant cannot perform a home exercise program or that there is indication for chiropractic therapy to exceed current treatment recommendations which is a trial of 6 sessions. Therefore, this request is not medically necessary.

Shockwave Therapy six (6) treatments for the lumbar spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 12th edition (web), 2014, Low Back, Shock Wave Therapy

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Shock Wave Therapy Page(s): 29, 371. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Shockwave Therapy

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines as well as the Official Disability Guidelines notes that shockwave therapy not recommended. The available evidence does not support the effectiveness of ultrasound or shock wave for treating low back pain. There is an absence in documentation noting extenuating circumstances to support shockwave therapy for the lumbar spine. Therefore, this request is not medically necessary and is not consistent with current treatment guidelines.