

<b>Case Number:</b>	CM14-0098878		
<b>Date Assigned:</b>	07/28/2014	<b>Date of Injury:</b>	08/06/2012
<b>Decision Date:</b>	08/29/2014	<b>UR Denial Date:</b>	06/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/27/2014

### 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 Occupational 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 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 49 year old kitchen prep worker who injured herself at work on 6 Aug 2012 when she tripped on an uneven step and fell, landing on her buttocks and causing pain in her neck, shoulders and lower back. Presently she has 7/10 pain in her lower back radiating into her left ankle and with numbness and tingling into her right heel and left thigh. She is able to perform activities of daily living (ADLs), however, she can not perform any activity over 20 minutes. She is depressed with associated difficulty sleeping and panic attacks which her primary care provider attributes to her ongoing pain and lower back dysfunction. Her most recent exam documented in the records available for review (2 Feb 2014) shows diffuse tenderness over lumbar paravertebral musculature and moderate facet tenderness over L4, L5 and S1, seated and supine straight leg raise is positive bilaterally and there is marked limitation of motion to forward flexion, lateral flexion and extension. Sensation is decreased on the right L3 and L5 dermatomes and the left L5 dermatome. There is mild decrease in strength to 4/5 of the right and left big toe extensors, the right knee extensors and the right hip extensors. No trigger points were identified. Xray and CT of her lower back and tailbone was normal. A MRI (10 Jan 2013) of the lumbar spine showed multilevel (L2-3 and L4-5) degenerative disc disease with abutment of descending right L3 and bilateral L5 nerve roots and mild central canal stenosis at L2-3 and L4-5. No nerve root compression is described. She was initially treated in the ER with an injection of pain medication (type not listed in records) and started on a pain medication (type not listed in available records). For a number of months (at least 5 documented in the available records) she has been continued on ibuprofen and prilosec with documentation of this medications causing a decrease of her pain to 5-6/10. She was begun on a home exercise program and aqua therapy but there is no documentation of the effectiveness of either therapy.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Dendracin Topical Lotion 120ML: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 274-8, Chronic Pain Treatment Guidelines (CPMTG) Part 1; Part 2 Page(s): 3-4; 28-9, 56-7, 111-13. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chp 6, pg108.

**Decision rationale:** Dendracin Lotion is a analgesic lotion composed of Methyl Salicylate 30%, Capsaicin 0.0375% and Menthol USP 10%. It is indicated for temporary relief of mild pain due to muscular strain, arthritis, and simple back pain. It does not cure any disease. Its use in this patient is inappropriate for a number of reasons. First, it is indicated for mild pain yet this patient has moderate to severe pain. Second, It is important to note that when any compounded product contains at least one drug that is not recommended, the entire compounded product is not recommended. Menthol and methyl salicylate is not recommended for chronic use. Individually the agents in this lotion, as discussed in the CPMTG Part 2, are indicated as follows: Menthol and methyl salicylates are used for neuropathic pain, osteoarthritis or tendonitis. They fall into the "Other" category of topical analgesics with little to no scientific literature to support their use. Their use should be limited to 4-12 weeks; Capsaicin is indicated for the treatment of osteoarthritis, post-herpetic neuralgia, diabetic neuropathy, post-mastectomy pain, fibromyalgia and chronic non-specific low back pain. And third, this patient has a symptomatic injury for over 2 years and thus meets the definition for chronic pain as described in ACOEM Guidelines Chp 6 and CPMTG, Part 1. Use of this lotion is for temporary relief of symptoms meant for short term use only. This is to allow time for improvement in function and activity using other therapeutic modalities. Its use in this patient as a chronic medication and without specific goals given for other treatment modalities, therefore, is inappropriate.

### **Aquatic Therapy 12 visits at 2 times per week for 6 weeks: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 339-340, Chronic Pain Treatment Guidelines Part 2 Page(s): 22, 46-7, 98-9.

**Decision rationale:** The literature reflects strong evidence that physical activity is key in returning individuals to function. Aqua therapy is supervised physical therapy in water used for relaxation, fitness and physical rehabilitation. The MTUS guidelines describes a random controlled study that showed effectiveness of aqua therapy for up to 8 months thus suggesting if this patient's aqua therapy is effective, it be continued for up to eight months. The goal of therapy, again, is a functional increase in the patient's activities of daily living or a reduction in

work restrictions. For this patient, however, there is no documentation on the effectiveness of this therapeutic modality on her functional status so its continued use is not indicated.

**Right L3-4 & Bilateral L5-S1 Epidural steroid injections x2: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 288, 309-10, Chronic Pain Treatment Guidelines Part 2 Page(s): 39-40, 46.

**Decision rationale:** The best medical evidence today for individuals with low back pain indicates that having the patient return to normal activities provides the best outcomes. Therapy should be guided, therefore, with modalities which will allow this outcome. Epidural steroid injections are an optional treatment for pain caused by nerve root inflammation as defined by pain in a specific dermatome pattern consistent with physical findings attributed to the same nerve root. As per the MTUS the present recommendation is for no more than 2 such injections, the second being done only if there is at least a partial response from the first injection. Its effects usually will offer the patient short term relief of symptoms as they do not usually provide relief past 3 months, so other treatment modalities are required to rehabilitate the patient's functional capacity. The MTUS provides very specific criteria for use of this therapy. Specifically, the presence of a radiculopathy documented by examination and corroborated by imaging, and evidence that the patient is unresponsive to conservative treatment. For this patient there is good documentation on examination of the radicular nature of the patient's symptoms but this is not well corroborated by MRI as the MRI only shows disc abutment to the nerve roots not compression or distortion of the roots. The records also lack evidence that the patient is unresponsive to conservative therapy. In fact, the patient is getting improvement with use of medications (ibuprofen). There is no documentation, though, of the effectiveness of other modalities of therapy, such as her home exercise program or the aqua therapy.

**Bilateral trigger point injection with ultrasound guidance: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309-10, Chronic Pain Treatment Guidelines Part 2 Page(s): 122.

**Decision rationale:** Trigger point injections are injections of medications, usually anesthetics and/or steroids although saline, glucose and other agents may also be used, into areas of muscles where pressure on these areas causes focal pain with or without radiation or referred pain. Criteria for use of this treatment modality includes pain over 3 months duration and documented trigger points on exam as evidenced by palpation that triggers local pain, referred pain and a twitch response and, important from the stand point of this patient, that there is no documented radiculopathy. Review of the available records reveal that none of the physical findings that would define a trigger point were documented for this patient. Also since the patient's providers

think the patient has a radiculopathy which accounts for her pain, use of trigger point injection would not be indicated. ACOEM guidelines do not recommend trigger point injections in patients with low back pain as there is limited research-based evidence that shows its effectiveness.

**Psychology Consultation:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 1 Prevention Page(s): 3, Chronic Pain Treatment Guidelines Part 1; Part 2 Page(s): 5-6; 40, 100-2.

**Decision rationale:** This patient is over 2 years past her date of injury and is still significantly disabled. It is well known that there are multiple barriers to recovery from work-related injuries and psychosocial barriers are common. Additionally, the patient's condition has caused development of an associated psychological condition which will require ongoing treatment. Psychological evaluations are in wide spread use for chronic pain populations for these reasons and are effective in distinguishing these barriers and determining psychosocial interventions. In order to move this patient into recovery her treatment will require adequate psychological support. This support should allow for development of coping skills for pain, improved quality of life, and should enhance the effectiveness of other treatment modalities.