

Case Number:	CM14-0184544		
Date Assigned:	12/01/2014	Date of Injury:	03/09/2001
Decision Date:	01/21/2015	UR Denial Date:	10/29/2014
Priority:	Standard	Application Received:	11/05/2014

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 Internal 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 an injured worker with a history of lumbosacral and lower extremity complaints. Date of injury was 03-09-2001. The progress report dated September 24, 2014 documented subjective complaints of right foot pain and right hip and groin and leg pain. Patient reports slight improvement with her right foot pain with acupuncture. The patient claims to have increased right hip and groin and leg pain. She has been walking less due to pain. Objective findings were documented. Lumbar flexion was decreased to 40 degrees. There is lumbar paraspinal spasm and midline tenderness. There is negative right lumbar facet maneuver and negative left lumbar facet maneuver. There is negative sacroiliac joint tenderness. There was negative sacroiliac joint stress test. The right straight leg test causes axial back pain at 60 degrees. Left straight leg raising test is negative and the rest of the functional spinal exam was normal. There is full right hip range of motion. There is positive right Patrick test. Negative left Patrick test was noted. There is right sub-trochanteric tenderness. There is weakly positive right sub-trochanteric stress test with pain and weakness. The right femoral stretch test was deferred. There is resolution of the pain with right plantar foot extension. She has flat feet. Diagnoses were regional musculoskeletal pain, status post L4-5 fusion with hardware for L4-5 spinal stenosis, right sub-trochanteric bursitis, chronic pain-induced depression, and pronated feet. Treatment plan was documented. The patient was advised to continue Baclofen. Biofreeze gel was recommended. The patient was given a prescription for aquatic therapy 6 sessions. The progress report dated October 29, 2014 documented that the patient reports continued improvement of her right foot pain with acupuncture. The patient claims to have resolution of the right hip and groin and leg pain. She has been walking more since last visit. Objective findings were documented. Lumbar flexion was increased to 50 degrees. Extension was slightly increased to 15 degrees with pain. Left side bending was increased to 20 degrees with contralateral pain. Right side bending

was slightly increased to 15 degrees. There was decreased lumbar paraspinal spasm and midline tenderness. There was negative right lumbar facet maneuver. Negative left lumbar facet maneuver was noted. There is negative sacroiliac joint tenderness. There is negative sacroiliac joint stress test. Right straight leg test causes axial back pain at 60 degrees. Left straight leg raising test rates low back pain at 45 degrees. Rest of the functional spinal exam was normal. There is full right hip range of motion. There is positive right Patrick test. There is decreased right sub-trochanteric tenderness. There is weakly positive right sub-trochanteric stress test with pain and weakness. There is resolution of the pain with right plantar foot extension. She has flat feet. The patient was responding to acupuncture. The patient had regional musculoskeletal pain. The patient was status post L4-5 fusion with hardware for L4-5 spinal stenosis. The patient has right sub-trochanteric bursitis. Diagnoses were displacement of lumbar intervertebral disc without myelopathy, lumbosacral spondylosis without myelopathy, lumbosacral radiculopathy, and lumbosacral sprain. Weight was 154 pounds. Height was 61 inches. Treatment plan was documented. The patient was advised to continue Baclofen. Biofreeze gel was recommended. The patient was given a prescription for aquatic therapy 6 sessions.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bio-freeze Gel 8oz. with 2 refills (1x3): 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): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic) Biofreeze® cryotherapy gel

Decision rationale: The Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines address topical analgesics. Topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. There is little to no research to support the use of many of these agents. The Official Disability Guidelines (ODG) states that Biofreeze gel is recommended as an optional form of cryotherapy for acute pain. The medical records document that the patient is status post L4-5 fusion with hardware for L4-5 spinal stenosis. The date of injury was 03-09-2001. Per the ODG, Biofreeze gel is optional for acute pain. Medical records document that the patient's conditions are chronic. Per MTUS, topical analgesics have few randomized controlled trials to determine efficacy or safety. There is little to no research to support the use of many of these agents. The request for Biofreeze gel is not supported by the MTUS or the ODG guidelines. Therefore, the request for Bio-freeze Gel 8oz. with 2 refills (1x3) is not medically necessary.

Aquatic Therapy sessions (lumbar/right hip) (1x6): Upheld

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

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

Decision rationale: The Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines state that aquatic therapy is an optional form of exercise therapy and an alternative to land-based physical therapy. Aquatic therapy is specifically recommended where reduced weight bearing is desirable, for example extreme obesity. The medical records do not document extreme obesity. The progress report dated October 29, 2014 documented that the patient's weight was 154 pounds. The patient has been walking more since the last visit. Per the MTUS, aquatic therapy is specifically recommended where reduced weight bearing is desirable, which is not exhibited in the medical records. Therefore, the request for aquatic therapy is not supported by the MTUS guidelines. Therefore, the request for Aquatic Therapy sessions (lumbar/right hip) (1x6) is not medically necessary.

Baclofen 10mg #20: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47, Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63-66. Decision based on Non-MTUS Citation FDA Prescribing Information Baclofen <http://www.drugs.com/pro/baclofen.html>

Decision rationale: The Medical Treatment Utilization Schedule (MTUS) addresses muscle relaxants. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) states that muscle relaxants seem no more effective than NSAIDs for treating patients with musculoskeletal problems, and using them in combination with NSAIDs has no demonstrated benefit. Muscle relaxants may hinder return to function by reducing the patient's motivation or ability to increase activity. Table 3-1 states that muscle relaxants are not recommended. Chronic Pain Medical Treatment Guidelines (page 63-66) addresses muscle relaxants. Muscle relaxants should be used with caution as a second-line option for short-term treatment. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. According to a review in American Family Physician, muscle relaxants should not be the primary drug class of choice for musculoskeletal conditions. Baclofen is recommended orally for the treatment of spasticity and muscle spasm related to multiple sclerosis and spinal cord injuries. FDA Prescribing Information states that Baclofen is indicated for spasticity resulting from multiple sclerosis. Baclofen may also be of some value in patients with spinal cord injuries and other spinal cord diseases. Baclofen is not indicated in the treatment of skeletal muscle spasm resulting from rheumatic disorders. The efficacy of Baclofen in stroke, cerebral palsy, and Parkinson's disease has not been established and, therefore, it is not recommended for these conditions. Medical records document that the patient has chronic occupational injuries and has been prescribed muscle relaxants long-term. MTUS guidelines do not support the long-term use of muscle relaxants. Medical records do not document multiple sclerosis or spinal cord injury. MTUS and FDA guidelines recommend Baclofen only for

multiple sclerosis or spinal cord diseases. MTUS, ACOEM, and FDA guidelines do not support the use of Baclofen. Therefore, the request for Baclofen 10mg #20 is not medically necessary.