

<b>Case Number:</b>	CM14-0190382		
<b>Date Assigned:</b>	12/24/2014	<b>Date of Injury:</b>	11/09/2011
<b>Decision Date:</b>	01/21/2015	<b>UR Denial Date:</b>	10/22/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/14/2014

### 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 Family Practice, 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 52 year-old woman who was injured at work on 11/9/2011. The injury was primarily to her neck, back and shoulders. She is requesting review of denial for the following: Physical Therapy with Cold Laser Treatment 2 X a week for 3 Weeks (Cervical); Norco 10/325 mg #60; Robaxin 500 mg #30; Ibuprofen 600 mg #60; a Urine Toxicology Screen; and a Retro Urine Toxicology Screen. Medical records corroborate ongoing care for his injuries. These records include the Primary Treating Physician's Progress Reports. At the last documented visit on 10/17/2014 the patient presented for ongoing pain in the upper back and neck. Diagnoses include: Cervical Radiculopathy; Encounter for Therapeutic Drug Monitoring; and Encounter for Long-Term Use of Other Medications. In the Utilization Review process each of these requests was non-certified; however, the retrospective request (9/23/2014) for a urine toxicology screen was modified to the following: A 10 panel random urine drug screen for qualitative analysis with confirmatory laboratory testing only performed on inconsistent results X1. Regarding the non-certification of physical therapy, it was noted that the patient has been treated for many years with chiropractic care, acupuncture and trigger point injections. She was sent to a chronic pain program but was expelled due to missed sessions. She had previously completed 10 sessions of physical therapy in 2011.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy with cold laser treatment 2 times a week for 3 weeks (cervical): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99. Decision based on Non-MTUS Citation ODG, Neck & Upper Back Procedure Summary

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

**Decision rationale:** The MTUS/Chronic Pain Medical Treatment Guidelines comment on the use of physical therapy as a treatment modality. These guidelines state the following: Physical therapy is recommended as indicated below. Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. The guidelines also provide specific recommendations as to the number of sessions allowed for a given medical condition. For example: Physical Medicine Guidelines - Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home exercise program. Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks. In this case, the patient has previously undergone a course of 10 physical therapy sessions. It would be expected that, per the guideline recommendations, she had been bridged to an active, self-directed home exercise program. There is no rationale provided as to why the patient requires additional physical therapy sessions above and beyond the prior care she has already received. There is no rationale provided as to why these physical therapy sessions require the use of "cold laser treatment." Under these conditions physical therapy with cold laser treatment 2 times a week for 3 weeks (cervical) is not considered as a medically necessary treatment.

**Norco 10/325mg, #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-78, 80.

**Decision rationale:** The MTUS/Chronic Pain Medical Treatment Guidelines comment on the long-term use of opioids. These guidelines have established criteria on the use of opioids for the ongoing management of pain. Actions should include: prescriptions from a single practitioner and from a single pharmacy. The lowest possible dose should be prescribed to improve pain and

function. There should be an ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. Pain assessment should include: current pain, the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. There should be evidence of documentation of the "4 A's for Ongoing Monitoring." These four domains include: pain relief, side effects, physical and psychological functioning, and the occurrence of any potentially aberrant drug-related behaviors. Further, there should be consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain that does not improve on opioids in 3 months. There should be consideration of an addiction medicine consult if there is evidence of substance misuse (Pages 76-78). Finally, the guidelines indicate that for chronic pain, the long-term efficacy of opioids is unclear. Failure to respond to a time-limited course of opioids has led to the suggestion of reassessment and consideration of alternative therapy (Page 80). Based on the review of the medical records, there is insufficient documentation in support of these stated MTUS/Chronic Pain Medical Treatment Guidelines for the ongoing use of opioids. There is insufficient documentation of the "4 A's for Ongoing Monitoring." The treatment course of opioids in this patient has extended well beyond the time-frame required for a reassessment of therapy. In summary, there is insufficient documentation to support the chronic use of an opioid in this patient. Treatment with Norco is not considered as medically necessary.

**Robaxin 500mg, #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxant. Decision based on Non-MTUS Citation ODG-TWC

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-65.

**Decision rationale:** The MTUS/Chronic Pain Medical Treatment Guidelines comment on the use of muscle relaxants such as Robaxin. These guidelines state that the non-sedating muscle relaxants are recommended with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. Sedation is the most commonly reported adverse effect of muscle relaxant medications. These drugs should be used with caution in patients driving motor vehicles or operating heavy machinery. Drugs with the most limited published evidence in terms of clinical effectiveness include chlorzoxazone, methocarbamol (Robaxin), dantrolene and baclofen. According to a recent review in American Family Physician, skeletal muscle relaxants are the most widely prescribed drug class for musculoskeletal conditions (18.5% of prescriptions), and the most commonly prescribed antispasmodic agents are carisoprodol, cyclobenzaprine, metaxalone, and methocarbamol (Robaxin), but despite their popularity, skeletal muscle relaxants should not be the primary drug class of choice for

musculoskeletal conditions. ANTISPASMODICS: Used to decrease muscle spasm in conditions such as LBP although it appears that these medications are often used for the treatment of musculoskeletal conditions whether spasm is present or not. The mechanism of action for most of these agents is not known. Methocarbamol (Robaxin, Relaxin™, generic available): The mechanism of action is unknown, but appears to be related to central nervous system depressant effects with related sedative properties. This drug was approved by the FDA in 1957. Side Effects: Drowsiness, dizziness and lightheadedness. Dosing: 1500 mg four times a day for the first 2-3 days, then decreased to 750 mg four times a day. In this case, there is no evidence provided in the medical record that the use of Robaxin is intended for the short-term treatment of an acute exacerbation of the patient's pain. Further, it is unclear whether the patient has been given an adequate trial of a "first-line" treatment for this problem. Finally, it appears from the evidence in the records that Robaxin has been used as a long-term treatment. The guidelines indicate that efficacy diminishes over time and this may lead to dependence. Therefore, under these conditions the use of Robaxin is not medically necessary.

**Ibuprofen 600mg, # 60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-68.

**Decision rationale:** The MTUS/Chronic Pain Medical Treatment Guidelines comment on the use of NSAIDs as a treatment modality. The guidelines state the following: Specific recommendations: Osteoarthritis (including knee and hip): Recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence to recommend one drug in this class over another based on efficacy. In particular, there appears to be no difference between traditional NSAIDs and COX-2 NSAIDs in terms of pain relief. The main concern of selection is based on adverse effects. COX-2 NSAIDs have fewer GI side effects at the risk of increased cardiovascular side effects, although the FDA has concluded that long-term clinical trials are best interpreted to suggest that cardiovascular risk occurs with all NSAIDs and is a class effect (with naproxyn being the safest drug). There is no evidence of long-term effectiveness for pain or function. Back Pain - Acute exacerbations of chronic pain: Recommended as a second-line treatment after acetaminophen. In general, there is conflicting evidence that NSAIDs are more effective than acetaminophen for acute LBP. For patients with acute low back pain with sciatica a recent Cochrane review (including three heterogeneous randomized controlled trials) found no differences in treatment with NSAIDs vs. placebo. In patients with axial low back pain this same review found that NSAIDs were not more effective than acetaminophen for acute low-back pain, and that acetaminophen had fewer side effects. The addition of NSAIDs or spinal manipulative therapy does not appear to increase recovery in patients with acute low back pain over that received with acetaminophen treatment and advice from their physician. Back Pain - Chronic low back pain: Recommended as an option for short-

term symptomatic relief. A Cochrane review of the literature on drug relief for low back pain (LBP) suggested that NSAIDs were no more effective than other drugs such as acetaminophen, narcotic analgesics, and muscle relaxants. The review also found that NSAIDs had more adverse effects than placebo and acetaminophen but fewer effects than muscle relaxants and narcotic analgesics. In addition, evidence from the review suggested that no one NSAID, including COX-2 inhibitors, was clearly more effective than another. Neuropathic pain: There is inconsistent evidence for the use of these medications to treat long-term neuropathic pain, but they may be useful to treat breakthrough and mixed pain conditions such as osteoarthritis (and other nociceptive pain) in with neuropathic pain. In this case, there is no evidence from a review of the medical records that Ibuprofen is being prescribed for the acute exacerbation of this patient's chronic pain. Further, there is no evidence that the patient has received an adequate trial of a first-line agent. It is unclear whether Ibuprofen is intended for the patient's neuropathic pain; however, if that is the case, the guidelines indicate that Ibuprofen would not be recommended as the primary agent for this condition. In summary, there is no evidence to support the use of Ibuprofen in this patient. Ibuprofen is not medically necessary.

**Urine toxicology screen:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Urine Drug Testing

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Drug Testing Page(s): 43.

**Decision rationale:** The MTUS/Chronic Pain Medical Treatment Guidelines comment on the use of drug testing. These guidelines state that drug testing is recommended as an option, using a urine drug screen to assess for the use or the presence of illegal drugs. In addition, the guidelines comment on the steps used to avoid misuse/addiction of opioids. These steps include the use of frequent random urine toxicology screens. Based on the information in the available medical records there is no evidence that the patient has engaged in any suspicious or aberrant behaviors to indicate that she is at high-risk for addiction. In summary, there is no evidence in the medical records to support the rationale for ordering a urine drug screen. This test is not medically necessary.

**Retro Urine toxicology screen:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Urine Drug Testing

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Drug Testing Page(s): 43.

**Decision rationale:** The MTUS/Chronic Pain Medical Treatment Guidelines comment on the use of drug testing. These guidelines state that drug testing is recommended as an option, using a urine drug screen to assess for the use or the presence of illegal drugs. In addition, the guidelines comment on the steps used to avoid misuse/addiction of opioids. These steps include

the use of frequent random urine toxicology screens. Based on the information in the available medical records there is no evidence that the patient has engaged in any suspicious or aberrant behaviors to indicate that she is at high-risk for addiction. In summary, there is no evidence in the medical records to support the rationale for ordering a urine drug screen. This test is not considered as medically necessary.