

Case Number:	CM14-0205198		
Date Assigned:	01/29/2015	Date of Injury:	08/13/2003
Decision Date:	02/23/2015	UR Denial Date:	11/30/2014
Priority:	Standard	Application Received:	12/08/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: New Jersey, Michigan, California
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

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 33 year old female who sustained a work related injury on August 13, 2003. The mechanism of injury was not provided. Current documentation dated November 3, 2014 notes that the injured worker reported low back pain radiating to both legs with associated numbness and tingling. She also complained of pain in the mid back which radiated to both shoulder blades and chest. The injured worker noted that current medications and topical creams were helpful to control the pain. Physical examination of the thoracic spine revealed positive tenderness over the thoracic paraspinal musculature. Lumbar spine examination showed tenderness to palpation over the lumbar paraspinal musculature. There was decreased range of motion noted secondary to pain and stiffness. Straight leg raise was positive in both lower extremities. Sensation was noted to be diminished to light touch and pinprick in the bilateral lumbar five and sacral one dermatomal distribution. Diagnoses include lumbar discopathy with disc displacement, thoracic musculoligamentous injury and lumbar radiculopathy. Work status is temporarily totally disabled. The treating physician requested Flexmid 7.5 mg # 120, Flurbiprofen 25%, Menthol 10%, Camphor 3%, Capsaisin 0.0375% 30 gm quantity 1, Flurbiprofen 25%, Menthol 10%, Camphor 3%, Capsaisin 0.0375% 120 gm quantity 1, a urine toxicology screening quantity 1, chiropractic manipulation/massage # 24, acupuncture sessions # 6, MRI of the thoracic spine # 1 and an MRI of the lumbar spine # 1. Utilization Review evaluated and denied the requests on November 30, 2014 for all issues at dispute except for the acupuncture request which was modified. MTUS ACOEM Guidelines do not recommended long term use of muscle relaxants such as Flexmid. In addition, there is lack of explicit

documentation of muscle spasms on examination and no documented functional improvement from any previous use. Therefore, the request for Flexmid is non-certified. The requests for the topical analgesics, Flurbiprofen 25%, Menthol 10%, Camphor 3%, Capsaicin 0.0375% 30 gm quantity 1 and Flurbiprofen 25%, Menthol 10%, Camphor 3%, Capsaicin 0.0375% 120 gm quantity 1 were non-certified per the CA MTUS Chronic Pain Medical Treatment Guidelines and Official Disability Guidelines which do not recommend topical analgesic creams as they are highly experimental without proven efficacy and only recommended for treatment of neuropathic pain after failed first line therapy. There is lack of documentation of the injured workers intolerance of these or similar medications. Therefore, the request for the topical creams is non-certified. The request for the urine toxicology screening was non-certified per CA MTUS Chronic Pain Medical Treatment Guidelines and Official Disability Guidelines. There is lack of documentation by the provider of concerns over the injured workers use of illicit drugs or non-compliance with prescriptions. In addition, there is no documentation of dates of previous drug screenings over the past twelve months and what those results were and any potential related actions taken. Therefore, the request is denied. The request for chiropractic manipulation/massage was non-certified due to lack of documentation of symptomatic or functional improvement from previous chiropractic sessions and CA MTUS Chronic Pain Medical Treatment Guidelines and Official Disability Guideline recommendations. The request for acupuncture sessions was modified per MTUS ACOEM Acupuncture Guidelines which recommends acupuncture for specifically identified musculo-skeletal conditions. The medical necessity for a trial of acupuncture is established. Therefore, the request was modified to six sessions. The request for an MRI of the lumbar and thoracic spine were denied due to lack of documentation of deficits in reflexes, muscle strength and results of therapy trial to date. In addition, there is no documentation of an acute clinical change since the date of the previous MRI. Therefore, the requests are non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fexmid 7.5 mg, # 120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 64 - 66.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 41.

Decision rationale: According to MTUS guidelines, non-sedating muscle relaxants are recommended with caution as a second line option for short term treatment of acute exacerbation in patients with chronic lumbosacral pain. Efficacy appears to diminish over time and prolonged use may cause dependence. In this case, the injured worker does not have clear evidence of acute exacerbation of chronic back pain and spasm. Evidence based guidelines do not recommend its use for more than 2-3 weeks. Therefore, this request is not medically necessary.

Flurbiprofen 25%/Menthol 10%/Camphor 3%/Capsaicin 0.0375% 30 gram cream: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Section Page(s): 111 - 113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Topical Analgesics Chapter

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

Decision rationale: According to MTUS, in Chronic Pain Medical Treatment guidelines section Topical Analgesics (page 111) stated topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Many agents are combined to other pain medications for pain control. That is limited research to support the use of many of these agents. Furthermore, according to MTUS guidelines, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. There is no evidence that Menthol or any other compound of the topical analgesic is recommended as topical analgesics for chronic back pain. Flurbiprofen, a topical analgesic is not recommended by MTUS guidelines. Based on the above, this request is not medically necessary.

Flurbiprofen 25%/Menthol 10%/Camphor 3%/Capsaicin 0.0375% cream, 120 grams:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Section Page(s): 111 - 113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Topical Analgesics Chapter

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

Decision rationale: According to MTUS, in Chronic Pain Medical Treatment guidelines section Topical Analgesics (page 111) stated topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Many agents are combined to other pain medications for pain control. That is limited research to support the use of many of these agents. Furthermore, according to MTUS guidelines, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. There is no evidence that Menthol or any other compound of the topical analgesic is recommended as topical analgesics for chronic back pain. Flurbiprofen, a topical analgesic is not recommended by MTUS guidelines. Based on the above, this request is not medically necessary.

Urine toxicology testing: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug Testing Section Page(s): 43.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Steps to Avoid Misuse/Addiction Page(s): 77-78; 94.

Decision rationale: According to MTUS guidelines, urine toxicology screens are indicated to avoid misuse or addiction. Consider the use of a urine drug screen to assess for the use or the presence of illegal drugs. In this case, there is no documentation of drug abuse or aberrant behavior. There is no documentation of drug abuse or misuse. There is no rationale provided for requesting urine drug screening (UDS) test. Therefore, this request is not medically necessary.

24 sessions of chiropractic manipulation/massage: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation and Massage Therapy Sessions Page(s).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Page(s): 58.

Decision rationale: According to MTUS guidelines, chiropractic treatment it is recommended for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. According to Official Disability Guidelines (ODG) stated there is limited evidence to specifically support the utilization of manipulative procedures of the shoulder, but this procedure is routinely applied by chiropractic providers whose scope allows it, and the success of chiropractic manipulation for this may be highly dependent on the patient's previous successful experience with a chiropractor. In general, it would not be advisable to use this modality beyond 2-3 visits if signs of objective progress towards functional restoration are not demonstrated. A recent clinical trial concluded that manipulative therapy for the shoulder girdle in addition to usual medical care accelerates recovery of shoulder symptoms. A recent meta-analysis concluded that there is limited evidence which supports the efficacy of manual therapy in patients with a shoulder impingement syndrome. There is fair evidence for the treatment of a variety of common rotator cuff disorders, shoulder disorders, adhesive capsulitis, and soft tissue disorders using manual and manipulative therapy (MMT) to the shoulder, shoulder girdle, and/or the full kinetic chain combined with or without exercise and/or multimodal therapy. There is limited and insufficient evidence for MMT treatment of minor neurogenic shoulder pain and shoulder osteoarthritis, respectively. According to this systematic review, manipulation performed about the same as steroid injections for frozen shoulder. The latest UK Health Technology Assessment on management of frozen shoulder concludes that based on the best available evidence there may be benefit from stretching and from high-grade mobilization technique. See also Physical therapy. In addition, ODG Chiropractic Guidelines stated the following recommendations regarding sprains and strains of shoulder and upper arm: Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home therapy and is recommended for 9 visits over 8 weeks. ODG guidelines did not recommend chiropractic treatment for back and neck pain beyond 2-3 visits without documentation of efficacy. Therefore, this request is not medically necessary.

24 sessions of acupuncture: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: According to MTUS guidelines, Acupuncture is 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. It is the insertion and removal of filiform needles to stimulate acupoints (acupuncture points). Needles may be inserted, manipulated, and retained for a period of time. Acupuncture can be used to reduce pain, reduce inflammation, increase blood flow, increase range of motion, decrease the side effect of medication-induced nausea, promote relaxation in an anxious patient, and reduce muscle spasm. Furthermore, according to MTUS guidelines, Acupuncture with electrical stimulation is the use of electrical current (microamperage or milli-amperage) on the needles at the acupuncture site. It is used to increase effectiveness of the needles by continuous stimulation of the acupoint. Physiological effects (depending on location and settings) can include endorphin release for pain relief, reduction of inflammation, increased blood circulation, analgesia through interruption of pain stimulus, and muscle relaxation. It is indicated to treat chronic pain conditions, radiating pain along a nerve pathway, muscle spasm, inflammation, scar tissue pain, and pain located in multiple sites. The patient developed chronic neck and back pain and musculoskeletal disorders. However, this request for 24 sessions of acupuncture exceeds guideline recommendations. Therefore, this request is not medically necessary.

MRI of the thoracic spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

Decision rationale: Regarding the indications for imaging in case of back pain, MTUS guidelines stated lumbar spine x-rays should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least six weeks. However, it may be appropriate when the physician believes it would aid in patient management. Unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic

resonance imaging [MRI] for neural or other soft tissue, computer tomography [CT] for bony structures). Furthermore, according to MTUS guidelines, an MRI is the test of choice for patients with prior back surgery, fracture or tumors that may require surgery. In this case, the patient does not have any clear evidence of new thoracic nerve root compromise. There is no clear evidence of significant change in the patient signs or symptoms suggestive of new pathology. Therefore, this request is not medically necessary.

MRI of the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

Decision rationale: Regarding the indications for imaging in case of back pain, MTUS guidelines stated lumbar spine x-rays should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least six weeks. However, it may be appropriate when the physician believes it would aid in patient management. Unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computer tomography [CT] for bony structures). Furthermore, according to MTUS guidelines, an MRI is the test of choice for patients with prior back surgery, fracture or tumors that may require surgery. In this case, the patient does not have any clear evidence of new thoracic nerve root compromise. There is no clear evidence of significant change in the patient signs or symptoms suggestive of new pathology. Therefore, this request is not medically necessary.