

Case Number:	CM15-0102303		
Date Assigned:	06/04/2015	Date of Injury:	10/07/2009
Decision Date:	07/08/2015	UR Denial Date:	04/21/2015
Priority:	Standard	Application Received:	05/27/2015

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: Colorado

Certification(s)/Specialty: Family Practice

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 injured worker is a 67 year old female, who sustained an industrial injury on 10/7/09. She reported right ankle, right hip, neck and low back injuries after slipping and falling. The injured worker was diagnosed as having lumbar radiculitis and degenerative disease of the cervical, lumbar spine and hips. Treatment to date has included cervical and lumbar epidural steroid injection, bilateral facet injections, oral medications including Fexmid, Ultram, Anaprox, Neurontin and Prilosec and activity restrictions. Currently, the injured worker complains of neck pain with radiation to right shoulder and down her right upper extremity into her thumb and low back pain with radiation to bilateral lower extremities associated with numbness. She rated her pain level 7/10 without medications and 4/10 with medications. She is currently temporarily totally disabled. Physical exam noted slightly limited range of motion of cervical spine, tenderness over the occipital nerves bilaterally, minimal tenderness over the cervical spinous processes and interspaces from C3-7, tenderness over facet joints bilaterally and significant tightness, tenderness and trigger points in the cervical paravertebral, trapezius, levator scapulae, supraspinatus and infraspinatus muscles bilaterally. Physical exam of the lumbar spine noted limited range of motion, minimal tenderness over the lumbar spinous processes and interspaces from L3 to S1, over the facet joints from L3-S1 bilaterally, tenderness over the sacroiliac joints bilaterally, mild tightness, tenderness and trigger points in the lumbar paravertebral, quadratus lumborum, gluteus medius, maximus and piriformis muscles bilaterally. The treatment plan included requests for authorization for trigger point injections, massage therapy and refills of oral medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fexmid 7.5mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Page(s): 42-43.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Treatments Page(s): 41-42, and 64.

Decision rationale: Cyclobenzaprine (Flexmid) and other antispasmodics are recommended for musculoskeletal pain associated with spasm, but only for a short course. It has been shown to help more than placebo with back pain and fibromyalgia, but has several side effects that limit its use. Furthermore, Cyclobenzaprine works best in the first 4 days of use, so short courses recommended, no more than 2-3 weeks. No quality, consistent evidence exists to support chronic use of Cyclobenzaprine. Common side effects of Cyclobenzaprine include: anticholinergic effects (drowsiness, urinary retention and dry mouth). Sedative effects may limit use. Headache has been noted. This medication should be avoided in patients with arrhythmias, heart block, heart failure and recent myocardial infarction. Side effects limit use in the elderly. (See, 2008) (Toth, 2004) The records supplied indicate patient has been taking Cyclobenzaprine greater than 3 months, albeit intermittently, and there is no documentation that her function or spasms have improved with the Cyclobenzaprine. As there is no support, per the guidelines, for long-term use and no documented sustained functional, spasm improvement, the request for Cyclobenzaprine is not medically necessary.

Anaprox 275mg #180: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 69.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Treatments Page(s): 22 and 68.

Decision rationale: Per the Guidelines, Non-steroidal anti-inflammatory drugs are considered first-line therapy for short-term, symptomatic relief of low back pain, and recent clinical trials support the use in chronic low back as an effective measure. However, "a Cochrane review of the literature" indicates non-steroidal anti-inflammatory drugs are no more effective than Acetaminophen, opioids, or muscle relaxers in treatment of low back pain. The non-steroidal anti-inflammatory drugs, though, do have more documented side effects and adverse events than Acetaminophen and fewer side effects than opioids and muscle relaxers. There is insufficient evidence to recommend one non-steroidal anti-inflammatory drug over another. Per the Guidelines, no consistent, quality evidence exists to support the use of Non-steroidal anti-inflammatory drugs in neuropathic pain, but some evidence suggests they may be useful in breakthrough pain, or combination pain syndromes (nociceptive pain with neuropathic pain).

Based on the records supplied, patient has a pain syndrome characterized by both nociceptive pain and neuropathic pain. The patient endorses some improvement in pain with Anaprox, and the pain ratings are consistently improved with medications relative to without medications. Patient does have pain relief with the Anaprox, though she has not resumed normal activity and work. Patient only to be using Anaprox as needed. Recent clinical trials suggest non-steroidal anti-inflammatory drugs may be useful in chronic low back pain, and patient has stable improvement in pain levels documented, so the request for Anaprox is medically necessary.

Massage therapy x 12 visits: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Massage therapy Page(s): 61.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 200 and 207, Chronic Pain Treatment Guidelines Pain Interventions and Treatments Page(s): 60.

Decision rationale: Per the MTUS Guidelines, massage therapy can be recommended as a treatment in addition to other recommended treatments (e.g. exercise). It is generally recommended to limit the number of massages to 4-6 visits. Available studies are not consistent, and lack long-term evaluations. Massage has been shown to be helpful with musculoskeletal symptoms, but only during the therapy, and dependence on massage therapy is not recommended. Massage therapy is a passive therapy which does not have proven long term benefits. Massage therapy does have some good studies that support its use to reduce stress and anxiety. Per the ACOEM, while massage for acute/subacute cervicothoracic pain and chronic radiculopathy can be recommended for up to 10 sessions before transitioning to "conditioning therapy," the evidence to support the recommendation is lacking. Myofascial release, a soft tissue treatment technique that is most commonly used in the periscapular area to treat non-specific muscle soreness, is not recommended for acute/subacute /chronic cervicothoracic pain and chronic radiculopathy. For the patient of concern, the requested massage therapy would include 12 sessions. Patient would not be participating in other exercise in addition to the proposed massage therapy, per the records. Based on the recommendations of the MTUS and ACOEM, the requested 12 sessions of massage therapy exceed the total recommended so the request is not medically necessary.

Bilateral trigger point injection over lumbar spine muscles: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger point injections Page(s): 122.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Treatments Page(s): 122.

Decision rationale: Per the guidelines, trigger point injections are only recommended for myofascial pain syndrome, which is specifically defined as a "regional painful muscle condition with a direct relationship between a specific trigger point and its associated pain region." While

trigger point injections, in some cases, have been used to maintain function, they are generally not of lasting value. A trigger point is defined as a localized area of tenderness and a taut band of skeletal muscle that can be palpated, resulting in a twitch in response to the palpation. Up to 50% of the adult population may have trigger points, but trigger point injections are only recommended when patient has myofascial pain syndrome that relates a trigger point to an area of referred pain. If patient has myofascial pain syndrome with unresolved trigger points, then trigger point injection with an anesthetic may be recommended. Addition of a steroid to the anesthetic in the injection is not generally recommended. Trigger point injections have not been proven effective and would therefore not be recommended in typical back or neck pain or in fibromyalgia. (Graff-Radford, 2004) (Nelemans-Cochrane, 2002) (Goldenberg, 2004) Trigger point injections would only be recommended in chronic low back or neck pain with myofascial pain syndrome if all criteria for use are met: Trigger points must be documented with evidence of twitch response and referred pain upon exam. Symptoms must be present for > 3 months. Medical therapies including muscle relaxers, non-steroidal anti-inflammatory drugs, and physical therapy have failed to improve symptoms. There should be no Radiculopathy, by exam, imaging or other testing. No more than 3-4 injections are to be done per session. Repeat injections are not indicated unless pain relief > 50% and evidence of function improvement after initial injection is documented. No injections at interval of less than 2 months. Use of anything in the trigger point injection other than local anesthetic with or without steroid is not recommended. (Colorado, 2002) (BlueCross BlueShield, 2004) Per the records supplied, the patient does have a diagnosis of myofascial pain syndrome for shoulder, neck and low back. There is no documented twitch response or referred pain for patient's trigger point(s). Patient does have lumbar radiculopathy by diagnosis / imaging / exam. The medication to be used in the trigger point injections is not specified in the records. Based on the records supplied, patient does not meet all of the criteria for trigger point injections, so the request is not medically necessary.

Prilosec 20mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms and Cardiovascular Risk Page(s): 69-70.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Treatments Page(s): 68.

Decision rationale: Per the MTUS Guidelines, Prilosec and other Proton pump inhibitors can be indicated for use with non-steroidal anti-inflammatory drugs, in those at high risk for gastrointestinal events, or in those on high dose / multiple medications that increase risk of gastrointestinal events. Per the Guidelines, a patient at intermediate risk for gastrointestinal event, but at no risk from cardiovascular event, would need a Proton Pump Inhibitor to protect stomach if using non-steroidal anti-inflammatory drug. To determine if patient needs Proton Pump Inhibitor, the following questions should be taken into consideration when providing non-steroidal anti-inflammatory drugs for pain patients: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). Patient of concern is over 65 years of age. The records do not indicate that she has had a history of peptic ulcer disease, or a history of gastroesophageal reflux. The dosing for patient's non-steroidal anti-inflammatory drug is low. While patient is at slightly increased risk of gastrointestinal events based on age, she has no other significant risk factors and no high dose medications that would place her at high risk. The request for Omeprazole is not medically necessary based on patient's relatively low risk for gastrointestinal events.