

<b>Case Number:</b>	CM15-0108388		
<b>Date Assigned:</b>	06/15/2015	<b>Date of Injury:</b>	04/18/2012
<b>Decision Date:</b>	09/23/2015	<b>UR Denial Date:</b>	06/03/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/05/2015

### 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: California

Certification(s)/Specialty: Emergency 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:

The injured worker is a 43 year old male who sustained an industrial injury on April 18, 2012. He has reported low back pain and has been diagnosed with lumbosacral joint ligament sprain/strain, right knee sprain/strain, lumbosacral or thoracic neuritis or radiculitis unspecified, history of NSAIDS induced gastritis. Treatment has included medications, a home exercise program, TENS unit, ice, and heat. There was limited lumbar range of motion. There was tenderness to palpation to the right trapezius muscle and tenderness to palpation of the lumbar spine and right lumbar paraspinal muscle spasms. There was tenderness to palpation of the medial aspect of the right knee. There was lumbar pain with movement and decreased sensation in the right lower extremity. There was weakness in the right lower extremity. The treatment request included Omeprazole, cyclobenzaprine, Norco, Lidopro cream, acupuncture, massage, infrared, therapeutic exercises, and supplies and materials.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cyclobenzaprine 7.5 mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 63-64.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63 of 127.

**Decision rationale:** The request is for the use of a muscle relaxant to aid in pain relief. The MTUS guidelines state that the use of a medication in this class is indicated as a second-line option for short-term treatment of acute exacerbations of low back pain. Muscle relaxants may be effective in reducing pain and muscle tension, which can increase mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain improvement. Efficacy appears to diminish over time, and prolonged use may lead to dependence. (Homik, 2004) Due to inadequate qualifying evidence for use of a muscle relaxant, the request is not medically necessary. All muscle relaxant medications should be titrated down slowly to prevent an acute withdrawal syndrome.

**Omeprazole 20 mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 68-69.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68 of 127.

**Decision rationale:** The request is for the use of a medication in the class of a proton pump inhibitor. This is usually given as an acid reducing medication for patients with esophageal reflux, gastritis, or peptic ulcer disease. It can also be used as a preventative measure in patients taking non-steroidal anti-inflammatories for chronic pain. Unfortunately, they do have certain side effects including gastrointestinal disease. The MTUS guidelines states that patients who are classified as intermediate or high risk, should be treated prophylactically. Criteria for risk are as follows: "(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)." Due to the fact the patient does not meet to above stated criteria, the request for use is not medically necessary.

**Norco 10/325 mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78-80, 91, 124.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78 of 127.

**Decision rationale:** The request is for the use of a medication in the opioid class. The MTUS guidelines state that for ongoing treatment with a pharmaceutical in this class, certain requirements are necessary. This includes not only adequate pain control, but also functional improvement. Four domains have been proposed for management of patients on opioids. This includes pain relief, side effects, physical and psychosocial functioning, and the occurrence of

any potentially aberrant drug-related behaviors. In this case, there is inadequate documentation of persistent functional improvement which should eventually lead to medication discontinuation. The records also do not reveal screening measures as discussed above for continued use of a medication in the opioid class. As such, the request is not medically necessary. All opioid medications should be titrated down slowly in order to prevent a significant withdrawal syndrome.

**Lidopro cream 121 gm:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 105, 111-113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111 to 113 of 127.

**Decision rationale:** The request is for the use of a compounded medication for topical use to aid in pain relief. These products contain multiple ingredients which each have specific properties and mechanisms of action. The MTUS guidelines state the following: "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." In this case, the compounded topical treatment contains an NSAID. Qualifying factors for this product is indicated by the following per the guidelines: The efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period. (Lin, 2004) (Bjordal, 2007) (Mason, 2004) When investigated specifically for osteoarthritis of the knee, topical NSAIDs have been shown to be superior to placebo for 4 to 12 weeks. Indications: Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. FDA-approved agents: Voltaren Gel 1% (diclofenac): Indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder. In this case, as stated above, the patient would not qualify for the use of a topical NSAID. This is based on the diagnosis and treatment duration. As such, the request is not medically necessary.

**Acupuncture - 6 visits:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

**Decision rationale:** The request is for acupuncture to aid in pain relief. The ACOEM guidelines state the following regarding this topic. "Acupuncture has not been found effective in the management of back pain, based on several high-quality studies, but there is anecdotal

evidence of its success." In this case the guidelines do not support the use of this treatment modality. This is secondary to the diagnosis with poor clinical evidence regarding efficacy. As such, the request is not medically necessary.

**Massage - 6 visits: Overturned**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 60 of 127.

**Decision rationale:** The request is for therapeutic massage. The MTUS guidelines state the following regarding this topic: Recommended as an option as indicated below. This treatment should be an adjunct to other recommended treatment (e.g. exercise), and it should be limited to 4-6 visits in most cases. Scientific studies show contradictory results. Furthermore, many studies lack long-term followup. Massage is beneficial in attenuating diffuse musculoskeletal symptoms, but beneficial effects were registered only during treatment. Massage is a passive intervention and treatment dependence should be avoided. This lack of long-term benefits could be due to the short treatment period or treatments such as these do not address the underlying causes of pain. (Hasson, 2004) A very small pilot study showed that massage can be at least as effective as standard medical care in chronic pain syndromes. Relative changes are equal, but tend to last longer and to generalize more into psychologic domains. (Walach 2003) The strongest evidence for benefits of massage is for stress and anxiety reduction, although research for pain control and management of other symptoms, including pain, is promising. The physician should feel comfortable discussing massage therapy with patients and be able to refer patients to a qualified massage therapist as appropriate. (Corbin 2005) Massage is an effective adjunct treatment to relieve acute postoperative pain in patients who had major surgery, according to the results of a randomized controlled trial recently published in the Archives of Surgery. (Mitchinson, 2007) In this case, as stated above, the request is reasonable. The guidelines state that a trial of 4-6 treatments is indicated to aid in pain relief. As such, the request is medically necessary.

**Infrared - 6 treatments: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 57 of 127.

**Decision rationale:** The request is for the use of low level laser therapy to aid in pain relief. The MTUS guidelines state the following regarding this topic: Not recommended. There has been interest in using low level lasers as a conservative alternative to treat pain. Low-level lasers, also known as "cold lasers" and non-thermal lasers, refer to the use of red-beam or near-infrared lasers with a wavelength between 600 and 1000 nm and wattage from 5-500 milliwatts. (In contrast, lasers used in surgery typically use 300 Watts.) When applied to the skin, these lasers

produce no sensation and do not burn the skin. Because of the low absorption by human skin, it is hypothesized that the laser light can penetrate deeply into the tissues where it has a photobiostimulative effect. One low-level laser device, the MicroLight 830 Laser, has received clearance for marketing from the U.S. Food and Drug Administration (FDA) specifically for the treatment of carpal tunnel syndrome. Other protocols have used low-level laser energy applied to acupuncture points on the fingers and hand. This technique may be referred to as "laser acupuncture." Given the equivocal or negative outcomes from a significant number of randomized clinical trials, it must be concluded that the body of evidence does not allow conclusions other than that the treatment of most pain syndromes with low level laser therapy provides at best the equivalent of a placebo effect. (Naeser, 2002) (Gur, 2002) (Basford, 1999) (Conti, 1997) (de Bie, 1998) (BlueCross BlueShield, 2005) Low Level Laser Therapy (LLLT) was introduced as an alternative non-invasive treatment for Osteoarthritis (OA) about 20 years ago, but its effectiveness is still controversial. For OA, the results are conflicting in different studies and may depend on the method of application and other features of the LLLT application. Despite some positive findings, data is lacking on how LLLT effectiveness is affected by four important factors: wavelength, treatment duration of LLLT, dosage and site of application over nerves instead of joints. There is clearly a need to investigate the effects of these factors on LLLT effectiveness for OA in randomized controlled clinical trials. (Brosseau-Cochrane, 2004) This meta-analysis concluded that there are insufficient data to draw firm conclusions about the effects of LLLT for low-back pain compared to other treatments, different lengths of treatment, different wavelengths and different dosages. (Yousefi-Nooraie-Cochrane, 2007) In this case, the use of low level laser therapy is not indicated. This is secondary to insufficient evidence regarding its effectiveness for this indication. As such, the request is not medically necessary.

### **Therapeutic exercises - 6 visits: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
Page(s): 58-60 of 127.

**Decision rationale:** The request is for therapeutic exercises to aid in pain relief. The MTUS guidelines states that manipulation 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. It is indicated for low back pain but not ankle and foot conditions, carpal tunnel syndrome, forearm/wrist/hand pain, or knee pain. The use of active treatment modalities instead of passive treatments is associated with substantially better clinical outcomes. (Fritz, 2007) Active treatments also allow for fading of treatment frequency along with active self-directed home PT, so that less visits would be required in uncomplicated cases. In this case, the patient would benefit most from at home active therapy. As such, the request is not medically necessary.

**Supplies and materials:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Unable to source due to non-specific request.

**Decision rationale:** The request is for supplies and materials. Unfortunately, the request is non-specific. The request must include the specific supplies and materials and well as quantity and the reason for the request. Pending this information, it cannot not be found medically necessary. As such, the request is not medically necessary.