MAXIMUS Federal Services

Case Number:	CM15-0134780		
Date Assigned:	07/29/2015	Date of Injury:	06/02/2010
Decision Date:	09/18/2015	UR Denial Date:	07/02/2015
Priority:	Standard	Application Received:	07/13/2015

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: New York
Certification(s)/Specialty: Anesthesiology

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 66 year old, female who sustained a work related injury on 6-2-10. The diagnoses have included myofascial pain syndrome and lumbar spine strain. Treatments have included oral medications, LidoPro ointment and use of a seated walker. In the PR-2 dated 6-25-15, the injured worker reports increased pain in lumbar spine. She is using medications and cream. She uses as seated walker for ambulation. On physical examination, she has positive trigger points in lumbar spine. She has decreased range of motion of lumbar spine in all planes. She has decreased sensation in buttocks. She has spasm and numbness of back. She is not working. The treatment plan includes refills of medications and ointment, requests for a urine drug screen, and for a back brace.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flexeril 7.5mg #90: 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 Cyclobenzaprine, Muscle Relaxants Page(s): 41-42, 63-64.

Decision rationale: According to the reviewed literature, Cyclobenzaprine (Flexeril) is closely related to the tricyclic antidepressants. It is not recommended for the long-term treatment of chronic pain. This medication has its greatest effect in the first four days of treatment. Guidelines state that this medication is not recommended to be used for longer than 2-3 weeks. According to CA MTUS Guidelines, muscle relaxants are not considered any more effective than non-steroidal anti-inflammatory medications alone. This medication has been in use for a minimum of 7 months. There is insufficient documentation on the effectiveness of pain relief or the relief of muscle spasms with the use of Flexeril. Since long-term use of Flexeril is not recommended and there is insufficient documentation of spasm relief, the request for Flexeril is not medically necessary.

Urine drug screen: Upheld

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

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

Decision rationale: According to CA MTUS, a urine drug screen is recommended as an option to assess for the use or the presence of illegal drugs. According to ODG, urine drug testing (UDT) is a recommended tool to monitor compliance with prescribed substances, identify use of undisclosed substances, and uncover diversion of prescribed substances. This patient is not taking any opioid medications. The urine drug screen done on 3/24/15 is negative for all drugs tested. There are no signs of abuse or misuse of any medications. Therefore, this requested treatment for a urine drug screen is not medically necessary.

Physical therapy to the lumbar spine twice a week for four weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98.

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

Decision rationale: Per CA MTUS guidelines, Chronic Pain Medical Treatment Guidelines, Physical Medicine Guidelines, physical therapy recommended as follows: "Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine; Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks; Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2) 8-10 visits over 4 weeks; Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks." The injured worker does not have any of the recommended diagnoses for treatment. She is beyond the early stages of her injury process. There is insufficient documentation of any previous physical therapy and if she

has been taught home exercises to be done on her own. For these reasons, the requested treatment of physical therapy is not medically necessary.

Purchase of a back brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chapter 1 Prevention Page(s): 9, 308. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Thoracic & Lumbar, Lumbar Support.

Decision rationale: According to the ACOEM guidelines, lumbar binders, corsets, or support belts are not recommended as treatment for low back pain. The guidelines state that the use of back-belts as lumbar support should be avoided because they have been shown to have little or no benefit, thereby providing only a false sense of security. In addition, the guidelines do not recommend lumbar braces for treatment of low back pain. Medical necessity for this item has not been established. Therefore, the lumbar brace is not medically necessary.

Trigger point injection times four to the bilateral lumbar paraspinal muscles with 5cc 1% lidocaine and 40mg Kenalog under ultrasound: 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 Trigger Point Injections Page(s): 122.

Decision rationale: Per the CA MTUS guidelines, trigger point injections are "recommended only for myofascial pain syndrome as indicated below, with limited lasting value. Not recommended for radicular pain. Trigger point injections with an anesthetic such as bupivacaine are recommended for non-resolving trigger points, but the addition of a corticosteroid is not generally recommended. Not recommended for radicular pain. These injections may occasionally be necessary to maintain function in those with myofascial problems when myofascial trigger points are present on examination. Not recommended for typical back pain or neck pain. Criteria for use of trigger point injections includes: trigger point injections with a local anesthetic may be recommended for the treatment of chronic low back or neck pain with myofascial pain syndrome when all of the following criteria are met: (1) Documentation of circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain; (2) Symptoms have persisted for more than three months; (3) Medical management therapies such as ongoing stretching exercises, physical therapy, NSAIDs and muscle relaxants have failed to control pain; (4) Radiculopathy is not present (by exam, imaging, or neuro-testing); (5) Not more than 3-4 injections per session; (6) No repeat injections unless a greater than 50% pain relief is obtained for six weeks after an injection and there is documented evidence of functional improvement; (7) Frequency should not be at an interval less than two months; (8) Trigger point injections with any substance (e.g., saline or glucose) other than local anesthetic with or without steroid are not

recommended." There is insufficient documentation on the trigger points and if any of the other treatments utilized have or have not been effective in the treatment of them. There is insufficient documentation of previous trigger point injections and if they were effective. The trigger points in lumbar spine are not specified as to location. For all of these reasons, the requested treatment of trigger point injections are not medically necessary.

Lidopro ointment #4: 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 Topical Analgesics Page(s): 111-113.

Decision rationale: According to the California MTUS Guidelines, topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, capsaicin, muscle relaxants, local anesthetics or antidepressants. Guidelines indicate that any compounded product that contains at least 1 non-recommended drug (or drug class) is not recommended for use. In this case, the requested topical analgesic compound, LidoPro cream, contains: Capsaicin, Lidocaine, Menthol and Methyl Salicylate. MTUS guidelines state that Lidocaine is not recommended for topical application for treatment of neuropathic pain. Capsaicin is recommended only as an option in patients who have not responded to, or are intolerant to other treatments. There is no documentation to support that the patient has neuropathic pain. The documentation does not support that the LidoPro ointment is improving pain levels or increasing her functional capabilities, or that the injured worker had failed a first line therapy for her pain. Medical necessity for the requested topical analgesic compound has not been established. The requested topical compound is not medically necessary.

Naproxen 550mg #100: 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 NSAIDS Page(s): 67-73.

Decision rationale: Per CA MTUS guidelines, Naproxen is a non-steroidal anti-inflammatory drug (NSAID) usually prescribed for osteoarthritis or pain. This injured worker has not been diagnosed with osteoarthritis. The provider does not document a rationale for requesting this medication. There are no documented improvements with his functional capabilities or changes in his pain levels from treatments already prescribed and utilized. Therefore, the requested treatment of Naproxen is not medically necessary.

Omeprazole 20mg #100: 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 NSAIDS Page(s): 67-73. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) PPIs.

Decision rationale: According to the CA MTUS, proton pump inhibitors, such as Omeprazole (Prilosec), are recommended for patients taking NSAIDs with documented GI distress symptoms or specific GI risk factors. Risk factors include, age >65, history of peptic ulcer disease, GI bleeding, concurrent use of aspirin, corticosteroids, and/or anticoagulants or high-dose/multiple NSAIDs. There is no documentation indicating the patient has any GI symptoms or GI risk factors. In this case, there is no documentation of any reported GI complaints. In addition, Naproxen was not found to be medically necessary. Medical necessity for Omeprazole has not been established. The requested medication is not medically necessary.

Neurontin 600mg #100: 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 Anti-epilepsy Drugs, Gabapentin, Neurontin Page(s): 16-22, 49, 67.

Decision rationale: Per CA MTUS guidelines, Neurontin (Gabapentin) "is an anti-epilepsy drug (AED) which has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain." "A recent review has indicated that there is insufficient evidence to recommend for or against antiepileptic drugs for axial low back pain." It is recommended for use in clients with chronic neuropathic pain. The patient does not complain of any neuropathic pain symptoms. There are no neurodiagnostic studies included in the medical records that demonstrate neuropathy. There is insufficient documentation on pain levels and functional capabilities. She has taken this medication for a minimum of 7 months. There is no documentation that pain levels have decreased or functional abilities have improved. The requested medication is not medically necessary.