

Case Number:	CM15-0142789		
Date Assigned:	08/03/2015	Date of Injury:	02/13/2007
Decision Date:	09/22/2015	UR Denial Date:	06/29/2015
Priority:	Standard	Application Received:	07/23/2015

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: Georgia

Certification(s)/Specialty: Anesthesiology, Pain Management

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 35 year old female, who sustained an industrial injury on 2-13-07 Initial complaints were not reviewed. The injured worker was diagnosed as having lumbar spinal stenosis. Treatment to date has included physical therapy; TENS unit; medications. Diagnostics studies included MRI cervical spine (4-13-12); MRI thoracic spine (4-13-12); MRI lumbar spine (4-13-12); EMG/NCV upper and lower extremities (4-16-12). Currently, the PR-2 notes dated 6-1-15 indicated the injured worker was in the office for a follow-up evaluation. She complains of neck, upper, lower back pain that radiates down into the bilateral lower extremities. She notes relief with applying heat and keeping the neck warm. She recently received a TENS unit and has been using it two to three times daily. She needs her medications refilled at this time. She reports without pain medications her pain level would be 7 over 10 and with it is 4-5 over 10. On physical examination, there is moderate pain over the left C6-C7 level with flexion rotations strained with paraspinal spasms on the left more than the right side. Range of motion of the cervical spine is complete with slight pain on right rotation, right lateral flexion with slight pull to the left. The lumbar spine has decreased lordosis with the left more than right dermatographia with moderate pain and spasms are noted over the left L4-L5 and L5-S1 segment. Bilateral seated straight leg raise is 90 degrees with pain referring to bilateral calves. Range of motion is with forward flexion at 55 degrees with moderate pain, extension 25 degrees with slight pain, bilateral flexion 45 degrees and bilateral lateral rotation 35 degrees with moderate pain referring to the left side. Her motor strength is 5 over 5 and sensibility is intact. The provider documents she is experiencing a flare up and will be provided medication refills. She continues to use her

TENS unit and recommends chiropractic treatments do address the cervical and lumbar regions. She continues full duty. The provider is requesting authorization of Chiropractic therapy to the cervical and lumbar spine with heat and low velocity joint mobs, 1-2 times per week, 6 times total; Lidocaine 5%, 12 hours on/ 12 hours off, #90, 6 refills; Etodolac 200mg, by mouth two times per day, #60, 6 refills; Tizanidine 4mg, by mouth every 6 hours, #60, 6 refills; Omeprazole 20mg, by mouth two times per day, #60, 6 refills and Ultracet 37.5/325mg, by mouth two times per day, #60, 6 refills.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic therapy to the cervical and lumbar spine with heat and low velocity joint mobs, 1-2 times per week, 6 times total: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & Manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chiropractor Therapy Page(s): 82.

Decision rationale: Chiropractic therapy to the cervical and lumbar spine with heat and low velocity joint mobs, 1-2 times per week, 6 times total is not medically necessary. Per CA MTUS Chiropractor, therapy is considered manual therapy. This therapy is recommended for chronic pain caused by musculoskeletal conditions. Manual therapy as well as the use in the treatment of muscular skeletal 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. For low back pain, manual therapy is recommended as an option. Therapeutic care requires a trial of six visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. Elective maintenance care is not medically necessary. For recurrences/flare-ups the need to reevaluate treatment success, if return to work achieved then 1-2 visits every 4-6 months. The patient had physical therapy and there is lack of documentation of response to therapy or an attempt to maximize benefit with home exercise therapy; therefore, the requested service is not medically necessary.

Lidocaine 5%, 12 hours on/ 12 hours off, #90, 6 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

Decision rationale: Lidoderm 5%, 12 hours on/ 12 hours off #90 Patches 6 Refills is not medically necessary. According to California MTUS, 2009, chronic pain, page 111 California MTUS guidelines does not cover "topical analgesics that are largely experimental in use with a few randomized controlled trials to determine efficacy or safety. Any compounded product that contains at least one drug or drug class that is not recommended, is not recommended". Additionally, Per CA MTUS page 111 states that topical analgesics are "recommended for

localized peripheral pain after there has been evidence of a trial of first-line therapy (anti-depressants or AED) Only FDA-approved products are currently recommended. Non-neuropathic pain: Not recommended. The claimant was not diagnosed with neuropathic pain and there is no documentation of physical findings or diagnostic imaging confirming the diagnosis; therefore, the requested medication is not medically necessary.

Etodolac 200mg, by mouth two times per day, #60, 6 refills: 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.

Decision rationale: Etodolac 200mg, by mouth two times per day, #60, 6 refills is not medically necessary. Per MTUS guidelines page 67, NSAIDs are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain so to prevent or lower the risk of complications associate with cardiovascular disease and gastrointestinal distress. The medical records do no document the length of time the claimant has been on Etodolac. Additionally, the claimant had previous use of NSAIDs. The medication is therefore not medically necessary.

Tizanidine 4mg, by mouth every 6 hours, #60, 6 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Muscle Relaxants.

Decision rationale: Tizanidine 4 mg, by mouth every 6 hours, #60, 6 refills is not medically necessary. The ODG states recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute LBP and for short-term treatment of acute exacerbations in patients with chronic LBP. Tizanidine (Zanaflex, generic available) is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain. (Malanga, 2008) Eight studies have demonstrated efficacy for low back pain. (Chou, 2007) One study (conducted only in females) demonstrated a significant decrease in pain associated with subacute and chronic myofascial pain syndrome and the authors recommended its use as a first line option to treat myofascial pain. (Malanga, 2002) May also provide benefit as an adjunct treatment for fibromyalgia. (ICSI, 2007) Side effects: somnolence, dizziness, dries mouth, hypotension, weakness, hepatotoxicity (LFTs should be monitored baseline, 1, 3, and 6 months). (See, 2008) Dosing: 4 mg initial dose; titrate gradually by 2 - 4 mg every 6 - 8 hours until therapeutic effect with tolerable side effects; maximum 36 mg per day. (See, 2008) Use with caution in renal impairment; should be avoided in hepatic impairment. Tizanidine use has been associated with hepatic aminotransaminase elevations that are usually asymptomatic and reversible with discontinuation. This medication is related to clonidine and should not be discontinued abruptly. Weaning should occur gradually, particularly in patients that have had prolonged use. (Zanaflex-FDA, 2008) This request is not medically necessary.

Omeprazole 20mg, by mouth two times per day, #60, 6 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk.

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

Decision rationale: Omeprazole 20 mg by mouth two times per day, #60, 6 refills is not medically necessary. CA MTUS does not make a direct statement on proton pump inhibitors (PPI) but in the section on NSAID use page 67. Long-term use of PPI, or misoprostol or Cox-2 selective agents have been shown to increase the risk of Hip fractures. CA MTUS does state that NSAIDs are not recommended for long-term use as well and if there possible GI effects of another line of agent should be used for example acetaminophen; therefore, the requested medication is not medically necessary.

Ultracet 37.5/325mg, by mouth two times per day, #60, 6 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol Page(s): 83.

Decision rationale: Ultracet 37.5/325 mg by mouth two times per day, #60, 6 refills is not medically necessary. Ultracet contains Tramadol. Tramadol is a centrally- acting opioid. Per MTUS page 83, opioids for osteoarthritis are recommended for short-term use after failure of first line non-pharmacologic and medication option including Acetaminophen and NSAIDS. Additionally, Page 79 of MTUS guidelines states that weaning of opioids are recommended if (a) there are no overall improvement in function, unless there are extenuating circumstances; (b) continuing pain with evidence of intolerable adverse effects; (c) decrease in functioning; (d) resolution of pain; (e) if serious non-adherence is occurring; (f) the patient requests discontinuing. The claimant's medical records did not document that there was an overall improvement in function or a return to work with previous opioid therapy. In fact, the claimant continued to report pain. Given Tramadol is a synthetic opioid, its use in this case is not medically necessary. The claimant has long-term use with this medication and there was a lack of improved function or return to work with this opioid and all other medications.