

Case Number:	CM15-0189659		
Date Assigned:	10/01/2015	Date of Injury:	02/23/2002
Decision Date:	12/04/2015	UR Denial Date:	08/28/2015
Priority:	Standard	Application Received:	09/25/2015

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 59 year old female who sustained an industrial injury on 02-23-2002. Current diagnoses include chronic low back pain, multi-level degenerative disc disease with radiculopathy, and myofascial pain. Report dated 08-16-2015 noted that the injured worker presented with complaints that included low back pain radiating to the right leg. Pain level was 7 (average), 6 (best), and 9 (worst) out of 10 on a visual analog scale (VAS). Current medications include Norco, ibuprofen, Zanaflex, and glucosamine-chondroitin. Physical examination performed on 08-16-2015 revealed tenderness in the lumbar paraspinal muscles, sore right hip, decreased sensation in the right leg along the S1 dermatomal distribution, numbness in the right hip to the bottom of the right leg, pain with backwards extension and facet loading, and left hip tenderness. Previous treatments included medications, surgical intervention, right pulsed radiofrequency at L5 and L2-L5 medial branch block radiofrequency on 02-09-2010, physical therapy, and water aerobics. The physician noted that the back pain and sciatica have improved since the hip surgery. The treatment plan included continuing Zanaflex, Glucosamine chondroitin, recommendation for a repeat diagnostic bilateral L3-4-5 medial branch block x 1, continue water aerobics program, and request for a weight loss program. The injured worker has been prescribed Zanaflex since at least 06-19-2015. The utilization review dated 08-28-2015, non-certified the request for Zanaflex, glucosamine-chondroitin, diagnostic bilateral L3-4-5 medial branch block x 1, and weight loss program.

IMR ISSUES, DECISIONS AND RATIONALES

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

Zanaflex 4 mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

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. Due to inadequate documentation of a recent acute exacerbation and poor effectiveness for chronic long-term use, the request is not medically necessary.

Glucosamine/Chondroitin 500/400 mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Glucosamine (and Chondroitin Sulfate).

Decision rationale: The request is for the use of glucosamine for pain relief. The MTUS guidelines state the following regarding this topic: Recommended as an option given its low risk, in patients with moderate arthritis pain, especially for knee osteoarthritis. Studies have demonstrated a highly significant efficacy for crystalline glucosamine sulphate (GS) on all outcomes, including joint space narrowing, pain, mobility, safety, and response to treatment, but similar studies are lacking for glucosamine hydrochloride (GH). A randomized, doubleblind placebo controlled trial, with 212 patients, found that patients on placebo had progressive joint-space narrowing, but there was no significant joint-space loss in patients on glucosamine sulphate. Another RCT with 202 patients concluded that long-term treatment with glucosamine sulfate retarded the progression of knee osteoarthritis, possibly determining disease modification. The Glucosamine Chondroitin Arthritis Intervention Trial (GAIT) funded by the National Institutes of Health concluded that glucosamine hydrochloride (GH) and chondroitin sulfate were not effective in reducing knee pain in the study group overall; however, these may be effective in combination for patients with moderate-to-severe knee pain. In this case, the use of glucosamine is not indicated. The patient does not meet the diagnostic criteria set for use. This is secondary to poor high-grade clinical evidence of efficacy for the patient's condition. As such, the request is not medically necessary.

Diagnostic bilateral L3-4-5 MBB X1: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Low Back Procedure Summary.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Facet joint medial branch blocks (therapeutic injections).

Decision rationale: The request is for a medial branch block to aid in pain relief. The ODG guidelines state the following regarding this topic: Not recommended except as a diagnostic tool. Minimal evidence for treatment. Pain Physician 2005: In 2005 Pain Physician published an article that stated that there was moderate evidence for the use of lumbar medial branch blocks for the treatment of chronic lumbar spinal pain. This was supported by one study. Patients either received a local anesthetic or a local anesthetic with methyl prednisolone. All blocks included Sarapin. Sixty percent of the patients overall underwent seven or more procedures over the 2 year study period (8.4 0.31 over 13 to 32 months). There were more procedures recorded for the group that received corticosteroids than those that did not (301 vs. 210, respectively). [Moderate evidence is a definition of the quality of evidence to support a treatment outcome according to Pain Physician.] The average relief per procedure was 11.9 3.7 weeks. Pain Physician 2007: This review included an additional randomized controlled trial. Controlled blocks with local anesthetic were used for the diagnosis (80% reduction of pain required). Four study groups were assigned with 15 patients in each group: (1) bupivacaine only; (2) bupivacaine plus Sarapin; (3) bupivacaine plus steroid; and (4) bupivacaine, steroid and Sarapin. There was no placebo group. Doses of 1-2ml were utilized. The average number of treatments was 3.7 and there was no significant difference in number of procedures noted between the steroid and non-steroid group. Long-term improvement was only thought to be possible with repeat interventions. All groups were significantly improved from baseline (a final Numeric Rating Scale score in a range from 3.5 to 3.9 for each group). Significant improvement occurred in the Oswestry score from baseline in all groups, but there was also no significant difference between the groups. There was no significant difference in opioid intake or employment status. There was no explanation posited of why there was no difference in results between the steroid and non-steroid groups. This study was considered positive for both short- and long-term relief, although, as noted, repeated injections were required for a long-term effect. Based on the inclusion of this study the overall conclusion was changed to suggest that the evidence for therapeutic medial branch blocks was moderate for both short- and long-term pain relief. Psychiatric comorbidity is associated with substantially diminished pain relief after a medial branch block injection performed with steroid at one-month follow-up. These findings illustrate the importance of assessing comorbid psychopathology as part of a spine care evaluation. The use of the blocks for diagnostic purposes is discussed in Facet joint diagnostic blocks (injections). The AHRQ comparative effectiveness study on injection therapies for LBP concluded that facet joint corticosteroid injections are not effective for presumed facet joint pain. See also Facet joint intra-articular injections (therapeutic blocks). In this case, the procedure is not supported by the guidelines. As stated above, there is poor clinical evidence of efficacy. As such, the request is not medically necessary.

Weight loss program: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medical Disability Advisor by Presley Reed, MD.

MAXIMUS guideline: Decision based on MTUS General Approaches 2004, Section(s): Prevention.

Decision rationale: The request is for participation in a weight loss program. The MTUS guidelines state the following regarding this topic: Strategies based on modification of individual risk factors (e.g., improving worker fitness, smoking cessation, weight loss) may be less certain, more difficult, and possibly less cost-effective. In particular, abdominal muscular strengthening to prevent low back pain is not supported by the existing evidence, whereas good aerobic condition is associated with a lower injury rate. Improving flexibility and strengthening of specific areas, such as the shoulder girdle, are recommended elsewhere (see Chapter 9, for example). An emphasis on aerobic conditioning may be appropriate to prevent musculoskeletal disorders. Aerobic fitness has other benefits as well, including improved productivity and job satisfaction. In this case, a weight loss program is not indicated. While modification of individual risk factors including weight loss is supported, there is no mention of specific weight loss programs as being more effective than self-directed activity. There is also no documentation of specific weight loss measures with results undertaken by the patient such as dietary modification or home exercise programs. As such, the request is not medically necessary.