

Case Number:	CM15-0032423		
Date Assigned:	02/25/2015	Date of Injury:	04/06/2011
Decision Date:	04/16/2015	UR Denial Date:	01/23/2015
Priority:	Standard	Application Received:	02/20/2015

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: Pennsylvania
 Certification(s)/Specialty: Internal 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 52 year old female who sustained an industrial injury on 4/6/11. Diagnoses include anxiety, left S1 nerve root radiculopathy, lumbago, dysthymic disorder/depression, chronic pain syndrome, myalgia and myositis, cervical and thoracic degenerative disc disease, and lumbar facet syndrome. Treatment to date has included physical therapy, lumbar epidural steroid injections, heat and ice, and medications. Bilateral lower extremity electromyogram/nerve conduction study (EMG/NCS) on 10/26/12 showed a degenerative radiculopathic process involving the S1 nerve root in the left lower extremity. Lumbar spine Magnetic Resonance Imaging (MRI) on 4/3/12 showed advanced facet arthropathy degeneration and capsulitis at L5-S1 with moderate foraminal narrowing; L4-5 facet hypertrophy with moderate to moderately severe narrowing of the left foraminal entrance zone at L4-5 level; there were also 2 facet synovial cysts; small annular fissure, slight degenerative type retrolisthesis and spondylotic changes at L3-4 without significant narrowing. The documentation indicates that medications included nucynta, flexeril, and norco and additional medications since March 2013, nucynta, flexeril, Elavil, norco and additional medications in August 2013, and nucynta, flexeril, Elavil, norco, and multiple additional medications in December 2013. Medications in May of 2014 included Cymbalta, Effexor, flexeril, nucynta, ambien, Elavil, norco, Xanax, and flector patch. The primary treating physician documented depression and anxiety for which the injured worker was taking Cymbalta, Effexor, Elavil, and Xanax. It was noted that medication gave more than 50% pain relief for 4-5 hours and allowed the injured worker to perform basic activities of daily living (ADLs). The physician documented that there

were no significant side effects or aberrant behavior and that the injured worker had a signed opioid contract; urine toxicology was performed at that office visit. In October 2014, the injured worker reported that she was doing fairly well mentally and that the medications were allowing her to do more overall. Urine drug screen on 7/15/14 was inconsistent. A urine drug screen in October 2014 was negative for alprazolam and hydrocodone, which were prescribed, and positive for nortriptyline which was not prescribed; these findings were inconsistent with prescribed medications. These findings were not addressed. There were reports from physical therapy with notation of 7 visits as of 12/18/14. At a visit on 1/14/15, the injured worker reported more neck pain and muscle tightness as well as ongoing low back pain. She had started physical therapy (PT) and felt that it was helping, and was performing exercises taught at PT. She reported medications helped manage pain and allowed her to do things. Examination showed 5 minus out of 5 upper extremity strength due to pain, intact sensation and negative Spurling's sign, tenderness to palpation of the cervical paraspinals and over facet joints at C4-5 and C6-7, normal strength and reflexes in the lower extremities with diminished sensation in the left L5-S1 dermatome, lumbosacral paraspinal tightness with muscle spasm and myofascial restrictions, and positive Patrick's sign and Gaenslen's maneuver on the left. Current medications were listed as norco, Effexor, flexeril, nucynta, Elavil, alprazolam, zolpidem, flector patch, gabapentin, and docusate. Work status was noted to be permanent and stationary. On 1/23/15, Utilization Review (UR) non-certified requests for additional physical therapy 6 sessions to the lumbar spine, initial massage therapy 6 sessions to the lumbar spine, norco 10/325 mg #60, Effexor XR 75mg #120, nucynta 200 mg #60, and Elavil 25mg #60. UR modified a request for flexeril 7.5 mg #60 to #20. UR cited the MTUS and ODG.

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional physical therapy, 1-2 times weekly, lumbar spine QTY: 6.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): p. 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter: physical medicine treatment.

Decision rationale: Physical medicine is recommended by the MTUS with a focus on active treatment modalities to restore flexibility, strength, endurance, function, and range of motion, and to alleviate discomfort. Per the MTUS, functional improvement is the goal rather than the elimination of pain. The maximum recommended quantity of physical medicine visits is 10, with progression to home exercise program. The ODG states that patients should be formally assessed after a six visit clinical trial to evaluate whether physical therapy has resulted in positive impact, no impact, or negative impact prior to continuing with or modifying the physical therapy. Both the MTUS and ODG note that the maximum number of sessions for unspecified myalgia and myositis is 9-10 visits over 8 weeks, and 8-10 visits over 4 weeks for neuralgia, neuritis, and radiculitis. As of 12/18/14, the injured worker had completed 7 physical therapy visits. The documentation submitted notes that the injured worker felt that physical therapy was helping, and

that she was performing a home exercise program. No specific functional improvement was noted as a result of the physical therapy already performed. It was not documented that the injured worker was working and the documentation suggests that she was not. Office visits continued at the same frequency of approximately every 1-2 months, and there was no documentation of decrease in medication use. The injured worker continued to report pain, and although she noted that therapy was helping, there was no discussion of improvement in specific activities of daily living. These findings do not represent a positive outcome from an initial trial of physical therapy. The injured worker was performing a home exercise program and would be expected to continue this. The injured worker has completed 7 sessions; the additional 6 sessions requested would be in excess of the guideline recommendation for a maximum of 10 sessions. Due to lack of functional improvement and number of sessions in excess of the guidelines, the request for additional physical therapy is not medically necessary.

Initial massage therapy, 1-2 times weekly, lumbar spine QTY: 6.00: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines massage therapy Page(s): p. 60.

Decision rationale: Per the MTUS, massage therapy should be used as an adjunct to exercise and limited to 4-6 visits in most cases. Massage is a passive intervention and treatment dependence should be avoided. The documentation indicates that the injured worker was performing a home exercise program. Examination of the lumbar spine showed muscle spasm and paraspinal tightness in spite of treatment with oral muscle relaxant medication. As the criteria for massage therapy are met and the number of sessions is within the guideline recommendations, the request for massage therapy is medically necessary.

Norco 10/325 QTY: 60.00: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 74-96.

Decision rationale: Norco and nucynta have been prescribed since at least March of 2013, for almost two years. There is no evidence that the treating physician is prescribing opioids according to the MTUS, which recommends prescribing according to function, with specific functional goals, return to work, random drug testing, and opioid contract. There should be a prior failure of non-opioid therapy. Although there was notation of an opioid contract and some drug testing, findings on at least two urine drug screens were inconsistent with prescribed medications, and these findings were not addressed. Per the MTUS, opioids are minimally indicated, if at all, for chronic non-specific pain, osteoarthritis, "mechanical and compressive etiologies," and chronic back pain. Some pain relief and nonspecific benefit with activities were

documented. Ongoing pain was noted; there is no evidence of significant pain relief or increased function from the opioids used to date. No specific improvement in activities of daily living were described. Work status was noted to be permanent and stationary, and the documentation suggests that the injured worker was not working. Office visits continued at the same frequency of approximately every 1-2 months, and there was no documentation of decrease in medication use. The MTUS states that a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. There is no evidence that the treating physician has utilized a treatment plan NOT using opioids, and that the patient "has failed a trial of non-opioid analgesics." Although the treating physician documented that there was no aberrant behavior, there was no discussion of the inconsistent findings on urine drug screens. As currently prescribed, Norco does not meet the criteria for long term opioids as elaborated in the MTUS and is therefore not medically necessary.

Effexor 7.5 mg QTY: 120: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 401-402, Chronic Pain Treatment Guidelines antidepressants p. 14-16, SNRIs p. 105, venlafaxine p. 123 Page(s): 14-16, 105, 123. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) mental illness and stress chapter: antidepressants for treatment of major depressive disorder and Other Medical Treatment Guidelines pdr.net: effexor.

Decision rationale: Venlafaxine (Effexor) is a selective serotonin and norepinephrine reuptake inhibitor (SNRI) which is FDA approved for treatment of depression and anxiety. It is recommended off-label for treatment of neuropathic pain, diabetic neuropathy, fibromyalgia, and headaches. The MTUS states that it is recommended as an option in first-line treatment of neuropathic pain. The MTUS states that antidepressants are recommended as a first line option for neuropathic pain and as a possibility for non-neuropathic pain. Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in use of other analgesic medication, sleep quality and duration, and psychological assessment. The ACOEM notes that brief courses of antidepressants may be helpful to alleviate symptoms of depression, but that given the complexity of available agents, referral for medication evaluation is advised. The ODG states that antidepressants offer significant benefit in the treatment of the severest depressive symptoms, but may have little or no therapeutic benefit over and above placebo in patients with mild to moderate depression. The documentation suggests that effexor was prescribed for depression. It has been prescribed for at least 9 months. In October 2014, the physician documented that the injured worker reported that she was doing fairly well mentally. There was no recent discussion of symptoms of depression and no detailed psychiatric evaluation or findings discussed. There was no documentation of functional improvement as a result of use off effexor. The documentation notes that work status was permanent and stationary and suggests that the injured worker was not working; there was no documentation of improvement in activities of daily living, decrease in medication use, or decrease in frequency of office visits as a result of use of effexor. Effexor may cause serotonin syndrome especially in combination with

other serotonergic drugs such as tricyclic antidepressants (such as elavil, a prescribed medication). Due to insufficient documentation of psychiatric symptoms and findings and lack of functional improvement as a result of effexor, the request for effexor is not medically necessary.

Nucynta 200 mg QTY: 60.00: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 74-96.

Decision rationale: Norco and nucynta have been prescribed since at least March of 2013, for almost two years. There is no evidence that the treating physician is prescribing opioids according to the MTUS, which recommends prescribing according to function, with specific functional goals, return to work, random drug testing, and opioid contract. There should be a prior failure of non-opioid therapy. Although there was notation of an opioid contract and some drug testing, findings on at least two urine drug screens were inconsistent with prescribed medications, and these findings were not addressed. Per the MTUS, opioids are minimally indicated, if at all, for chronic non-specific pain, osteoarthritis, "mechanical and compressive etiologies," and chronic back pain. Some pain relief and nonspecific benefit with activities were documented. Ongoing pain was noted; there is no evidence of significant pain relief or increased function from the opioids used to date. No specific improvement in activities of daily living were described. Work status was noted to be permanent and stationary, and the documentation suggests that the injured worker was not working. Office visits continued at the same frequency of approximately every 1-2 months, and there was no documentation of decrease in medication use. The MTUS states that a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. There is no evidence that the treating physician has utilized a treatment plan NOT using opioids, and that the patient "has failed a trial of non-opioid analgesics." Although the treating physician documented that there was no aberrant behavior, there was no discussion of the inconsistent findings on urine drug screens. As currently prescribed, nucynta does not meet the criteria for long term opioids as elaborated in the MTUS and is therefore not medically necessary.

Elavil 25 mg QTY: 60.00: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 401-402, Chronic Pain Treatment Guidelines antidepressants p. 14-16. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) mental illness and stress chapter: antidepressants for treatment of major depressive disorder and Other Medical Treatment Guidelines pdr.net: amitriptyline, effexor.

Decision rationale: The MTUS states that antidepressants are recommended as a first line option for neuropathic pain and as a possibility for non-neuropathic pain. Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in use of other analgesic medication, sleep quality and duration, and psychological assessment. The ACOEM notes that brief courses of antidepressants may be helpful to alleviate symptoms of depression, but that given the complexity of available agents, referral for medication evaluation is advised. The ODG states that antidepressants offer significant benefit in the treatment of the severest depressive symptoms, but may have little or no therapeutic benefit over and above placebo in patients with mild to moderate depression. The injured worker had a diagnosis of depression, and the documentation suggests that elavil was prescribed primarily for this reason. It has been prescribed since at least August 2013, for more than one year. In October 2014, the physician documented that the injured worker reported that she was doing fairly well mentally. There was no recent discussion of symptoms of depression and no detailed psychiatric evaluation or findings discussed. There was no documentation of functional improvement as a result of use off elavil. The documentation notes that work status was permanent and stationary and suggests that the injured worker was not working; there was no documentation of improvement in activities of daily living, decrease in medication use, or decrease in frequency of office visits as a result of use of elavil. Elavil may cause serotonin syndrome in combination with other serotonergic drugs such as effexor, a prescribed medication. Due to insufficient documentation of psychiatric symptoms and findings and lack of functional improvement as a result of elavil, the request for elavil is not medically necessary.

Flexeril 7.5 mg QTY: 60.00: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines cyclobenzaprine p. 41-42, muscle relaxants p. 63-66 Page(s): 41-42, 63-66.

Decision rationale: The MTUS for chronic pain does not recommend muscle relaxants for chronic pain. Non-sedating muscle relaxants are an option for short-term exacerbations of chronic low back pain. The muscle relaxant prescribed in this case is sedating. The injured worker has chronic pain with no evidence of prescribing for flare-ups. The quantity prescribed implies long term use, not for a short period of use for acute pain. No reports show any specific and significant improvement in pain or function as a result of prescribing muscle relaxants. Per the MTUS chronic pain medical treatment guidelines, cyclobenzaprine (Flexeril, fexmid) is a skeletal muscle relaxant and a central nervous system depressant. It is recommended as an option for a short course of therapy, with greatest effect in the first four days of treatment. Guidelines state that treatment should be brief. The addition of cyclobenzaprine to other agents is not recommended. Limited, mixed evidence does not allow for a recommendation for chronic use. Flexeril has been prescribed for more than one year, since March of 2013, which is greatly in excess of the guideline recommendations. It has consistently been used in combination with other medications, which is also not consistent with guideline recommendations. The documentation from a recent physical examination showed continued muscle spasm in spite of its use. There was no documentation of functional improvement as a result of prescription of

flexeril. No specific improvement in activities of daily living were described. Work status was noted to be permanent and stationary, and the documentation suggests that the injured worker was not working. Office visits continued at the same frequency of approximately every 1-2 months, and there was no documentation of decrease in medication use. Due to lack of functional improvement, continued findings of muscle spasm, and length of use in excess of the guidelines, the request for flexeril is not medically necessary.