

<b>Case Number:</b>	CM15-0034331		
<b>Date Assigned:</b>	03/02/2015	<b>Date of Injury:</b>	02/26/2012
<b>Decision Date:</b>	04/13/2015	<b>UR Denial Date:</b>	02/03/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/24/2015

### 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: Maryland, Texas, Virginia

Certification(s)/Specialty: Internal Medicine, Allergy and Immunology, Rheumatology

### 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 31 year old female, who sustained an industrial injury on February 26, 2012. She has reported lower back pain with radiation to the right leg and sleep difficulties. The diagnoses have included intervertebral disc disorder, lumbago, and lumbosacral spine strain/sprain. Treatment to date has included medications, physical therapy, chiropractic treatments, exercise, transforaminal epidural steroid injection, facet joint injections, acupuncture, and imaging studies. A progress note dated January 13, 2015 indicates a chief complaint of continued lower back pain with radiation to the right leg and sleep difficulties. Physical examination showed significant tenderness to palpation of the lumbar spine, and increased pain with range of motion. The treating physician requested a urine drug screen, prescription for Ultram, Botox injection, eight sessions of physical therapy following injection, prescription for Ibuprofen, prescription for Elavil, thirty day trial of a transcutaneous electrical nerve stimulation unit, and a handicap placard. On February 3, 2015 Utilization Review certified the request for the urine drug screen and prescription for Ultram. Utilization Review denied the request for the Botox injection, eight sessions of physical therapy following injection, prescription for Ibuprofen, prescription for Elavil, thirty day trial of a transcutaneous electrical nerve stimulation unit, and a handicap placard. The California Medical Treatment Utilization Schedule California Chronic Pain Medical treatment Guidelines were cited in the decisions. On February 24, 2015, the injured worker submitted an application for IMR of a request for a Botox injection, eight sessions of physical therapy following injection, prescription for Ibuprofen, prescription for

Elavil, thirty day trial of a transcutaneous electrical nerve stimulation unit, and a handicap placard.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Botox 400 units:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Botulinum toxin Page(s): 25-26.

**Decision rationale:** MTUS states regarding Botox injections, "Not recommended for the following: tension-type headache; migraine headache; fibromyositis; chronic neck pain; myofascial pain syndrome; & trigger point injections". Additionally MTUS states Botox injections are "Recommended: cervical dystonia, a condition that is not generally related to workers' compensation injuries (also known as spasmodic torticollis), and is characterized as a movement disorder of the nuchal muscles, characterized by tremor or by tonic posturing of the head in a rotated, twisted, or abnormally flexed or extended position or some combination of these positions" and "Recommended: chronic low back pain, if a favorable initial response predicts subsequent responsiveness, as an option in conjunction with a functional restoration program." The medical records provided did not indicate any conditions that MTUS recommends as appropriate for Botox Injections. The medical records fail to document cervical dystonia or functional restoration program. Also, Botox injections are not recommended for treatment of chronic pain disorders. As such, the request for Botox 400 units is not medically necessary.

**Physical Therapy 8 sessions to be performed after injection:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315, Chronic Pain Treatment Guidelines Physical Therapy, Physical Medicine Page(s): 98-99.

**Decision rationale:** California MTUS guidelines refer to physical medicine guidelines for physical therapy and recommends 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". Additionally, ACOEM guidelines advise against passive modalities by a therapist unless exercises are to be carried out at home by patient. ODG quantifies its recommendations with 10 visits over 8 weeks for lumbar sprains/strains and 9 visits over 8 weeks for unspecified backache/lumbago. ODG further states that a "six-visit clinical trial" of physical therapy with documented objective and subjective improvements should occur initially before additional

sessions are to be warranted. Medical records indicate that the physical therapy is for after the Botox injections. The Botox injections were not recommended. As such, the request for Physical Therapy 8 session to be performed after injection is not medically necessary.

**Ibuprofen 800mg #90 w/ 2 refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Ibuprofen, NSAIDS Page(s): 67-72 California MTUS guidelines refer to physical medicine guidelines for physical therapy and recommends 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.

**Decision rationale:** MTUS recommends the use of NSAIDS for the acute exacerbation of back pain at the lowest effective dose for the shortest amount of time due to the increased cardiovascular risk, renal, hepatic and GI side effects associated with long term use. MTUS states "Ibuprofen (Motrin, Advil (OTC), generic available): 300, 400, 600, 800 mg. Dosing: Osteoarthritis and off-label for ankylosing spondylitis: 1200 mg to 3200 mg daily. Individual patients may show no better response to 3200 mg as 2400 mg, and sufficient clinical improvement should be observed to offset potential risk of treatment with the increased dose. Higher doses are generally recommended for rheumatoid arthritis: 400-800 mg PO 3-4 times a day, use the lowest effective dose. Higher doses are usually necessary for osteoarthritis. Doses should not exceed 3200 mg/day. Mild pain to moderate pain: 400 mg PO every 4-6 hours as needed. Doses greater than 400 mg have not provided greater relief of pain". The medication is not being used for an exacerbation of her back pain, it is being used for her chronic low back pain. The treating physician did not document a decrease in pain or functional improvement from the use of Ibuprofen. As such the request for Ibuprofen 800mg #90 with 2 refills is not medically necessary.

**Elavil 15mg #30 w/ 2 refills:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain Page(s): 13. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain, TCAs.

**Decision rationale:** MTUS states that "Amitriptyline is a tricyclic antidepressant. Tricyclics are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated". ODG states "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. Side effects, including excessive sedation (especially that which would affect work performance) should be assessed. (Additional side effects are listed below for each specific drug.) It is recommended that these outcome

measurements should be initiated at one week of treatment with a recommended trial of at least 4 weeks. The optimal duration of treatment is not known because most double-blind trials have been of short duration (6-12 weeks). It has been suggested that if pain is in remission for 3-6 months, a gradual tapering of anti-depressants may be undertaken". ODG states "Dosing Information: Amitriptyline: Neuropathic pain: The starting dose may be as low as 10-25 mg at night, with increases of 10-25 mg once or twice a week up to 100 mg/day. (ICSI, 2007) The lowest effective dose should be used (Dworkin, 2007)". The medical records fail to meet the above guidelines to utilize Amitriptyline. There is no diagnosis of neuropathic pain. As such the request for Elavil 15mg #30 with 2 refills is not medically necessary.

**TENS Unit for a 30-day trial:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 114-116.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation, Transcutaneous electrotherapy Page(s): 54, 114-116, 118-120. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Tens chronic pain (transcutaneous electrical nerve stimulation).

**Decision rationale:** MTUS states regarding TENS unit, "Not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration, for the conditions described below". For pain, MTUS and ODG recommend TENS (with caveats) for neuropathic pain, phantom limb pain and CRPSII, spasticity, and multiple sclerosis. The medical records do not indicate any of the previous conditions. ODG further outlines recommendations for specific body parts: Low back: Not recommended as an isolated intervention. Knee: Recommended as an option for osteoarthritis as adjunct treatment to a therapeutic exercise program. Neck: Not recommended as a primary treatment modality for use in whiplash-associated disorders, acute mechanical neck disease or chronic neck disorders with radicular finding. Ankle and foot: Not recommended. Elbow: Not recommended. Forearm, Wrist and Hand: Not recommended. Shoulder: Recommended for post-stroke rehabilitation. Medical records do not indicate conditions of the low back, knee, neck, ankle, elbow, or shoulders that meet guidelines. Of note, medical records do not indicate knee osteoarthritis. ODG further details criteria for the use of TENS for Chronic intractable pain (for the conditions noted above): (1) Documentation of pain of at least three months duration (2) There is evidence that other appropriate pain modalities have been tried (including medication) and failed (3) A one-month trial period of the TENS unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; rental would be preferred over purchase during this trial (4) Other ongoing pain treatment should also be documented during the trial period including medication usage (5) A treatment plan including the specific short- and long-term goals of treatment with the TENS unit should be submitted (6) After a successful 1-month trial, continued TENS treatment may be recommended if the physician documents that the patient is likely to derive significant therapeutic benefit from continuous use of the unit over a long period of time. At this point purchase would be preferred over rental. (7) Use for acute pain

(less than three months duration) other than post-operative pain is not recommended. (8) A 2-lead unit is generally recommended; if a 4-lead unit is recommended, there must be documentation of why this is necessary

**Handicap Placard:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation [http://www.dmv.ca.gov/portal/dmv/detail/pubs/brochures/fast\\_facts/ffvr07](http://www.dmv.ca.gov/portal/dmv/detail/pubs/brochures/fast_facts/ffvr07).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation [REDACTED].

**Decision rationale:** The MTUS is silent on handicap placards. [REDACTED] states that persons may qualify for a handicap placard if, "you have impaired mobility due to having lost use of one or more lower extremities, or both hands, or have a diagnosed disease that substantially impairs or interferes with mobility, or one who is severely disabled to be unable to move without the aid of an assistive device. You may also qualify if you have specific, documented visual problems, including lower-vision or partial-sightedness". In this case, the patient fails to meet the above criteria. As such, the request for Handicap Placard is not medically necessary.