

<b>Case Number:</b>	CM15-0042298		
<b>Date Assigned:</b>	03/12/2015	<b>Date of Injury:</b>	10/15/2007
<b>Decision Date:</b>	04/16/2015	<b>UR Denial Date:</b>	02/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/05/2015

### 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: North Carolina  
 Certification(s)/Specialty: Family Practice

### 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 56-year-old male, who sustained an industrial injury on October 15, 2007. He reported that while driving a company truck the injured worker was rear-ended, with headache, difficulty with walking, stiffness and severe pain in the neck, right shoulder, and low back reported the following day. The injured worker was diagnosed as having lower back sprain/strain and sciatica, cervical spine sprain/strain with radiculopathy, and right shoulder sprain/strain. Treatment to date has included physical therapy and medication. Currently, the injured worker complains of pain to the head most of the time, neck pain, blurry vision and radiation to the shoulder blades and arms, right shoulder pain, and low back pain. The Primary Treating Physician's report dated February 3, 2015, noted examination of the cervical spine revealed tenderness to palpation over the right paraspinal musculature, right scapular region, and right trapezius, with palpable muscle spasms and rigidity. Sensation was noted diminished along the right C5-C6 dermatomes. The right shoulder examination revealed tenderness to palpation over the right anterior, posterior, and lateral aspect of the shoulder as well as the right paraspinal, right trapezius, and right scapular region. The lumbar spine examination revealed tenderness to palpation over the bilateral lumbar paravertebral musculature, bilateral pelvic brims, bilateral SI joints, and bilateral buttocks. Straight leg raise was positive on the right side in the sitting and supine positions. Sensation was noted to be diminished along the right L3-L4 dermatome.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy two times four for the cervical spine: 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): 98-99.

**Decision rationale:** The California chronic pain medical treatment guidelines section on physical medicine states: Recommended as indicated below. Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. (Colorado, 2002) (Airaksinen, 2006) Patient-specific hand therapy is very important in reducing swelling, decreasing pain, and improving range of motion in CRPS. (Li, 2005) The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of patients with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment. (Fritz, 2007) Physical Medicine Guidelines: 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 requested amount of physical therapy is in excess of California chronic pain medical treatment guidelines. The patient has already completed a course of physical therapy. There is no explanation why the patient would need excess physical therapy and not be transitioned to active self-directed physical medicine. In the absence of such documentation, the request cannot be certified.

**Magnetic resonance imaging (MRI) of the cervical spine: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 182.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173-174.

**Decision rationale:** The ACOEM chapter on neck and upper back complaints and special diagnostic studies states: Criteria for ordering imaging studies are: Emergence of a red flag; Physiologic evidence of tissue insult or neurologic dysfunction; Failure to progress in a strengthening program intended to avoid surgery; Clarification of the anatomy prior to an invasive procedure. The provided progress notes fails to show any documentation of indications for imaging studies of the neck as outlined above per the ACOEM. There was no emergence of red flag. The neck pain was characterized as unchanged. The physical exam noted no evidence of new tissue insult or neurologic dysfunction. There is no planned invasive procedure. Therefore, criteria have not been met for a MRI of the neck and the request is not certified.

**Tramadol 150mg #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 76-84.

**Decision rationale:** The California chronic pain medical treatment guidelines section on opioids states for ongoing management: On-Going Management. Actions Should Include: (a) Prescriptions from a single practitioner taken as directed, and all prescriptions from a single pharmacy. (b) The lowest possible dose should be prescribed to improve pain and function. (c) Office: Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Information from family members or other caregivers should be considered in determining the patient's response to treatment. The 4 A's for Ongoing Monitoring: Four domains have been proposed as most relevant for ongoing monitoring of chronic pain patients on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or non-adherent) drug-related behaviors. These domains have been summarized as the "4 A's" (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. (Passik, 2000) (d) Home: To aid in pain and functioning assessment, the patient should be requested to keep a pain diary that includes entries such as pain triggers, and incidence of end-of-dose pain. It should be emphasized that using this diary will help in tailoring the opioid dose. This should not be a requirement for pain management. (e) Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control. (f) Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion). (g) Continuing review of overall situation with regard to non-opioid means of pain control. (h)

Consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. Consider a psych consult if there is evidence of depression, anxiety or irritability. Consider an addiction medicine consult if there is evidence of substance misuse. When to Continue Opioids (a) If the patient has returned to work (b) If the patient has improved functioning and pain (Washington, 2002) (Colorado, 2002) (Ontario, 2000) (VA/DoD, 2003) (Maddox-AAPM/APS, 1997) (Wisconsin, 2004) (Warfield, 2004) The long-term use of this medication class is not recommended per the California MTUS unless there documented evidence of benefit with measurable outcome measures and improvement in function. There is no documented significant improvement in VAS scores. There is no provided objective improvement in function. Therefore, criteria for the ongoing use of opioids have not been met and the request is not certified.

**Ketoprofen transdermal gel 120gm: 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): 111-113.

**Decision rationale:** The California chronic pain medical treatment guidelines section on topical analgesics states: Recommended as an option as indicated below. Largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. (Namaka, 2004) These agents are applied locally to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. (Colombo, 2006) Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, -adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor). (Argoff, 2006) There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Non-steroidal anti-inflammatory agents (NSAIDs): The efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period. (Lin, 2004) (Bjordal, 2007) (Mason, 2004) When investigated specifically for osteoarthritis of the knee, topical NSAIDs have been shown to be superior to placebo for 4 to 12 weeks. In this study, the effect appeared to diminish over time and it was stated that further research was required to determine if results were similar for all preparations. (Biswal, 2006) These medications may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. (Mason, 2004) Indications: Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Neuropathic

pain: Not recommended as there is no evidence to support use. FDA-approved agents: Voltaren Gel 1% (diclofenac): Indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder. Maximum dose should not exceed 32 g per day (8 g per joint per day in the upper extremity and 16 g per joint per day in the lower extremity). The most common adverse reactions were dermatitis and pruritus. (Voltaren package insert) For additional adverse effects: See NSAIDs, GI symptoms and cardiovascular risk; & NSAIDs, hypertension and renal function. Non FDA-approved agents: Ketoprofen: This agent is not currently FDA approved for a topical application. It has an extremely high incidence of photocontact dermatitis. (Diaz, 2006) (Hindsen, 2006) Absorption of the drug depends on the base it is delivered in. (Gurol, 1996). Topical treatment can result in blood concentrations and systemic effect comparable to those from oral forms, and caution should be used for patients at risk, including those with renal failure. (Krummel 2000) Topical analgesic NSAID formulations are not indicated for long-term use and have little evidence for treatment of the spine, hip or shoulder. This patient does not have a diagnosis of osteoarthritis or neuropathic pain that has failed first line treatment options. Therefore, criteria for the use of topical NSAID therapy per the California MTUS have not been met and the request is not certified.