

<b>Case Number:</b>	CM15-0055530		
<b>Date Assigned:</b>	03/30/2015	<b>Date of Injury:</b>	09/16/2013
<b>Decision Date:</b>	05/11/2015	<b>UR Denial Date:</b>	03/11/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/23/2015

### 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: Massachusetts

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 (IW) is a 45-year-old female who sustained an industrial injury on 09/16/2013. Diagnoses include cervical spine sprain/strain with cervicogenic headaches; post-concussive syndrome; right monocular lateral hemianopsia; lumbar spine sprain/strain and fractured left mandibular molars-status post extraction. Treatment to date has included medications, trigger point injections and physical therapy. Diagnostics performed to date included ophthalmology and neurology evaluations, X-rays and MRIs. According to the progress notes dated 3/2/15, the IW reported increased neck pain with associated cervicogenic headaches, with migraine symptoms, occurring about 15 days per month, lasting four to six hours each time. On physical examination, the IW exhibited right lateral hemianopsia, decreased right nasolabial fold, slight deviation of the tongue to the right and ptosis of the right eye. It was stated that trigger point injections decreased her pain by 50% for two weeks and physical therapy for her cervical and lumbar spine had been beneficial. A request was made for physical therapy two times weekly for six weeks for the cervical spine; Botulinum toxin 300 units cervical, occipital, forehead and temporal region; Anaprox DS; Prilosec; Ultracet and Lidopro topical analgesic ointment. Anaprox was proposed as a preventative measure for the headaches and Botox as a treatment. The treatment plan also included psychotherapy and neuro ophthalmology.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy 2X6 weeks for the cervical spine: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98.

**Decision rationale:** Physical Medicine is recommended as indicated below. Passive therapy (those treatment modalities that do not require energy expenditure on the part of the injured worker) 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). Injured workers 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. Injured worker-specific hand therapy is very important in reducing swelling, decreasing pain, and improving range of motion in CRPS. 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 injured workers 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. 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. According to the documents available for review, the injured worker has previously undergone numerous sessions of PT without objective documented functional improvement. Further sessions of PT would be in contrast to the guidelines as set forth in the MTUS. Therefore, at this time, the requirements for treatment have not been met and medical necessity has not been established.

**Botulinum toxin 300 units cervical, suboccipital, forehead and temporal region: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Botulinum toxin (Botox; Myobloc) Page(s): 25 and 26.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Botox Page(s): 25.

**Decision rationale:** According to the MTUS, Botox is not recommended for migraine headache. Therefore, at this time, the requirements for treatment have not been met and medical necessity has not been established.

**Anaprox DS 550mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-68 and 73.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67 and 70-73.

**Decision rationale:** According to the MTUS Anti-inflammatories is the traditional first line of treatment, to reduce pain so activity and functional restoration can resume, but long-term use may not be warranted. Recommended with cautions below. Disease-State Warnings for all NSAIDs: All NSAIDS have [U.S. Boxed Warning]: for associated risk of adverse cardiovascular events, including, MI, stroke, and new onset or worsening of pre-existing hypertension. NSAIDS should never be used right before or after a heart surgery (CABG - coronary artery bypass graft). NSAIDs can cause ulcers and bleeding in the stomach and intestines at any time during treatment (FDA Medication Guide). See NSAIDs, GI Symptoms and Cardiovascular Risks. Other disease-related concerns (non-boxed warnings): Hepatic: Use with caution in injured workers with moderate hepatic impairment and not recommended for injured workers with severe hepatic impairment. Borderline elevations of one or more liver enzymes may occur in up to 15% of injured workers taking NSAIDs. Renal: Use of NSAIDs may compromise renal function. FDA Medication Guide is provided by FDA mandate on all prescriptions dispensed for NSAIDS. Routine Suggested Monitoring: Package inserts for NSAIDs recommend periodic lab monitoring of a CBC and chemistry profile (including liver and renal function tests). There has been a recommendation to measure liver transaminases within 4 to 8 weeks after starting therapy, but the interval of repeating lab tests after this treatment duration has not been established. Routine blood pressure monitoring is recommended. Overall Dosing Recommendation: It is generally recommended that the lowest effective dose be used for all NSAIDs for the shortest duration of time consistent with the individual injured worker treatment goals. According to the documents available for review, it appears that the injured worker is taking this medication for long-term therapy of a chronic condition. Given the increased risks associated with long-term use of this medication and no documented evidence that the lowest possible dose is being used for the shortest period of time, the requirements for treatment have not been met and medical necessity has not been established.

**Prilosec 20mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms and cardiovascular risk Page(s): 68 and 69.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines PPI  
Page(s): 68 and 69.

**Decision rationale:** The MTUS makes the following recommendations for the use of proton pump inhibitors. Clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. Determine if the injured worker is at risk for gastrointestinal events: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). Recent studies tend to show that H. Pylori does not act synergistically with NSAIDs to develop gastroduodenal lesions. Recommendations Injured workers with no risk factor and no cardiovascular disease: Non-selective NSAIDs OK (e.g., ibuprofen, Naproxen, etc.) Injured workers at intermediate risk for gastrointestinal events and no cardiovascular disease: (1) A non-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg Omeprazole daily) or misoprostol (200g four times daily) or (2) a Cox-2 selective agent. Long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture (adjusted odds ratio 1.44). Injured workers at high risk for gastrointestinal events with no cardiovascular disease: A Cox-2 selective agent plus a PPI if absolutely necessary. Injured workers at high risk of gastrointestinal events with cardiovascular disease: If GI risk is high the suggestion is for a low-dose Cox-2 plus low dose Aspirin (for cardioprotection) and a PPI. If cardiovascular risk is greater than GI risk the suggestion is Naproxyn plus low-dose aspirin plus a PPI. Cardiovascular disease: A non-pharmacological choice should be the first option in injured workers with cardiac risk factors. It is then suggested that acetaminophen or aspirin be used for short term needs. An opioid also remains a short-term alternative for analgesia. Major risk factors (recent MI, or coronary artery surgery, including recent stent placement): If NSAID therapy is necessary, the suggested treatment is Naproxyn plus low-dose aspirin plus a PPI. Mild to moderate risk factors: If long-term or high-dose therapy is required, full-dose naproxen (500 mg twice a day) appears to be the preferred choice of NSAID. If Naproxyn is ineffective, the suggested treatment is (1) the addition of aspirin to Naproxyn plus a PPI, or (2) a low-dose Cox-2 plus ASA. According to the records available for review the injured worker does not meet any of the guidelines required for the use of this medication therefore, at this time, the requirements for treatment have not been met and medical necessity has not been established.

**Ultracet 37.5 and/or 325mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids and Weaning of Medications Page(s): 78-80, 93-94 and 124. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids  
Page(s): 74-97.

**Decision rationale:** According to the MTUS Chronic Pain Medical Treatment Guidelines section on Opioids, On-Going Management, pages 74-97, (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 injured worker'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 injured worker'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 injured workers on opioids: pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or nonadherent) 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. (d) Home: To aid in pain and functioning assessment, the injured worker 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 injured worker 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 nonopioid 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. Additionally, the MTUS states that continued use of opioids requires (a) the injured worker has returned to work, (b) the injured worker has improved functioning and pain. There is no current documentation of baseline pain, pain score with use of opioids, functional improvement on current regimen, side effects or review of potentially aberrant drug taking behaviors as outlined in the MTUS and as required for ongoing treatment. Therefore, at this time, the requirements for treatment have not been met and medical necessity has not been established.

**Lidopro topical analgesic ointment BID:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topicals Page(s): 111-113.

**Decision rationale:** According to the MTUS, there is little to no research to support the use of topical compounded creams. The use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. Topical analgesics are largely experimental and there are a few randomized controlled trials to determine efficacy or safety. Therefore, at this time, the requirements for treatment have not been met and medical necessity has not been established.