

<b>Case Number:</b>	CM15-0076356		
<b>Date Assigned:</b>	04/28/2015	<b>Date of Injury:</b>	11/21/2014
<b>Decision Date:</b>	08/04/2015	<b>UR Denial Date:</b>	03/17/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/21/2015

### 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: New York  
 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 24 year old female who sustained a work related injury November 21, 2014. While lifting a container, approximately 50 pounds, in and out of a sink, she felt a click in her neck and back with an onset of pain. According to a primary treating physician's progress report dated February 20, 2015, the injured worker presented with complaints of pain in the neck, mid/upper back, rated 7/10, and lower back, rated 6/10. There is grade 2-3 tenderness to palpation over the paraspinal muscles of the cervical spine and thoracic spine which has remained the same since the last visit. The cervical compression test is positive. There is grade 2 tenderness to palpation over the paraspinal muscles, which have decreased for 2-3 since the last visit. There is restricted range of motion and the straight leg raise test is positive bilaterally. Diagnostic impression is documented as head pain; cervical spine musculoligamentous strain/sprain with radiculitis; thoracic spine musculoligamentous strain/sprain; lumbar spine musculoligamentous strain/sprain with radiculitis. Treatment plan included request for authorization for continued physical therapy, Anaprox DS, Cyclobenzaprine, compounded topical creams, purchase of a hot/cold unit, purchase of back support, purchase of an interferential unit, and urine toxicology screen.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Anaprox DS (Naproxen Sodium) 550mg #60: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67.

**Decision rationale:** As per MTUS Guidelines Anaprox is a non-steroidal anti-inflammatory medication (NSAID). This type of medication is recommended for the treatment of chronic pain as a second line of therapy after acetaminophen. The documentation indicates the patient has been maintained on long-term NSAID therapy and there has been no compelling evidence presented by the provider to document that the patient has had any significant functional improvements from this medication. Medical necessity for the requested treatment has not been established. The requested treatment is not medically necessary.

**Cyclobenzaprine 7.5mg #90: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-TWC Pain Procedure Summary Online Version (updated 02/23/2015).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Cyclobenzaprine (Flexeril) Page(s): 63-65. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter --Muscle relaxants Cyclobenzaprine (Flexeril).

**Decision rationale:** According to the reviewed literature, Cyclobenzaprine (Flexeril) is not recommended for the long-term treatment of chronic pain. This medication has its greatest effect in the first four days of treatment. In addition, this medication is not recommended to be used for longer than 2-3 weeks. According to CA MTUS Guidelines, muscle relaxants are not considered any more effective than nonsteroidal anti-inflammatory medications alone. In this case, the available records do not indicate that the injured worker has muscle spasms, and frequency and duration for which this medication is prescribed is not mentioned. Based on the currently available information, the medical necessity for this muscle relaxant medication has not been established. The requested treatment is not medically necessary.

**Flurbiprofen 20% / Lidocaine 5%/ Amitriptyline 5% 180gm: Upheld**

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

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

**Decision rationale:** According to the California MTUS Guidelines (2009), topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, capsaicin, muscle relaxants, local anesthetics or antidepressants. Guidelines indicate that any compounded product that contains at least one non-recommended drug (or drug class) is not recommended for use. Records do not indicate that injured worker is not able to use oral medications. There is no documentation in the submitted Medical Records that the injured worker has failed a trial of antidepressants and anticonvulsants. In this injured worker, the medical necessity for the requested topical cream has not been established. Therefore, as per guidelines stated above, the requested topical cream is not medically necessary.

**Gabaclozepam 10%/ Cyclobenzaprine 6%/ Tramadol 10% 180gm:** Upheld

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

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

**Decision rationale:** According to the California MTUS Guidelines (2009), topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, capsaicin, muscle relaxants, local anesthetics or antidepressants. Guidelines indicate that any compounded product that contains at least one non-recommended drug (or drug class) is not recommended for use. As per MTUS There is no evidence for use of any other muscle relaxant as a topical product. Gabapentin is not recommended. There is no peer-reviewed literature to support its use. Records do not indicate that injured worker is not able to use oral medications. There is no documentation in the submitted Medical Records that the injured worker has failed a trial of antidepressants and anticonvulsants. In this injured worker, the medical necessity for the requested topical cream has not been established. Therefore, as per guidelines stated above, the requested topical cream is not medically necessary.

**Urine Toxicology:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-TWC Pain Procedure Summary Online Version (updated 02/23/2015).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Urine Drug Testing (UDT).

**Decision rationale:** ODG state (1) UDT is recommended at the onset of treatment of a new patient who is already receiving a controlled substance or when chronic opioid management is considered. Urine drug testing is not generally recommended in acute treatment settings (i.e. when opioids are required for nociceptive pain). (2) In cases in which the patient asks for a specific drug. This is particularly the case if this drug has high abuse potential; the patient refuses other drug treatment and/or changes in scheduled drugs, or refuses generic drug substitution. (3) If the patient has a positive or "at risk" addiction screen on evaluation. This may also include evidence of a history of comorbid psychiatric disorder such as depression, anxiety, bipolar disorder, and/or personality disorder. See Opioids, screening tests for risk of addiction & misuse. (4) If aberrant behavior or misuse is suspected and/or detected. Review of Medical Records does not indicate substance abuse, noncompliance, or aberrant behavior. The treating provider does not provide any documentation about the need for Urine Toxicology. Guidelines are not met; therefore, the request is not medically necessary.

**Purchase of back support:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-TWC Low Back Procedure Summary Online Version (updated 01/30/2015).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter- Low Back - Lumbar & Thoracic (Acute & Chronic-Lumbar supports).

**Decision rationale:** This request for Back Brace (Lumbar Back Support ) is evaluated in light of the MTUS recommendations and Official Disability Guidelines (ODG). As per MTUS-ACOEM lumbar supports have not been shown to have any lasting benefit beyond the acute phase of low back pain. Official Disability Guidelines (ODG) does not recommend it for prevention. There is strong and consistent evidence that lumbar supports were not effective in preventing neck and back pain. Lumbar supports do not prevent LBP. A systematic review on preventing episodes of back problems found strong, consistent evidence that exercise interventions are effective and other interventions not effective, including stress management, shoe inserts, back supports, ergonomic/back education, and reduced lifting programs. This systematic review concluded that there is moderate evidence that lumbar supports are no more effective than doing nothing in preventing low-back pain. Official Disability Guidelines (ODG) Recommends it as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific LBP (very low-quality evidence, but may be a conservative option. Among home care workers with previous low back pain, adding patient-directed use of lumbar supports to a short course on healthy working methods may reduce the number of days when low back pain occurs, but not overall work absenteeism. Acute osteoporotic vertebral compression fracture management includes bracing, analgesics, and functional restoration. Medical Records of the injured worker indicate chronic low back pain. As per submitted medical records and Guidelines cited, the back brace is not medically necessary and appropriate.

**Purchase of interferntial unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-TWC Low Back Procedure Summary Online Version updated (01/30/2015).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter- Knee & Leg (Acute & Chronic -Interferential current therapy (IFC)).

**Decision rationale:** As per Official Disability Guidelines (ODG) Interferential current therapy (IFC) is under study for osteoarthritis and recovery post knee surgery. Not recommended for chronic pain or low back problems. After knee surgery, home interferential current therapy (IFC) may help reduce pain, pain medication taken, and swelling while increasing range of motion, resulting in quicker return to activities of daily living and athletic activities. Based on the currently available information in the submitted Medical Records of this injured worker, and per review of the guidelines, the medical necessity for Interferential Current Stimulation (ICS) unit has not been established. Requested Treatment for Interferential Current Stimulation (ICS) is not medically necessary.

**Purchase of Hot/cold unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-TWC Low Back Procedure Summary Online Version (updated 01/30/2015).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg Chapter--Cold/heat packs.

**Decision rationale:** ODG recommends Ice massage compared to control had a statistically beneficial effect on ROM, function and knee strength. Cold packs decreased swelling. Hot packs had no beneficial effect on edema compared with placebo or cold application. Ice packs did not affect pain significantly compared to control in patients with knee osteoarthritis. ODG states Continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. This meta-analysis showed that cryotherapy has a statistically significant benefit in postoperative pain control, while no improvement in postoperative range of motion or drainage was found. As the cryotherapy apparatus is fairly inexpensive, easy to use, has a high level of patient satisfaction, and is rarely associated with adverse events, we believe that cryotherapy is justified in the postoperative management of surgery. Although the use of equipment is appropriate post-operatively, the medical records neither indicate that this injured worker had any recent surgery nor, is scheduled to have one. As such, there is no indication for use of cold unit at this time. For heat therapy, special equipment is not needed. ODG also state mechanical circulating units with pumps have not been proven to be more effective than passive hot and cold therapy. The requested treatment: purchase of Cold/Heat therapy unit is not medically necessary and appropriate.