

Case Number:	CM14-0133279		
Date Assigned:	08/22/2014	Date of Injury:	10/17/2001
Decision Date:	10/06/2014	UR Denial Date:	08/08/2014
Priority:	Standard	Application Received:	08/20/2014

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. The expert reviewer is Board Certified in Family Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

Patient is a 59-year-old male who has submitted a claim for cervical strain, left ankle straight with fracture status post-surgery, right lumbar radiculopathy, thoracic strain, posttraumatic headaches, right shoulder strain with secondary left shoulder pain, left knee strain status post arthroscopy, depression, insomnia, MTP joint strain, and bilateral metatarsalgia associated with an industrial injury date of 10/17/2001. Medical records from 2014 were reviewed. The patient complained of neck pain, rated 8/10 in severity, with intense radiation to the scapular region, shoulder, and upper arms. The patient likewise complained of bilateral shoulder pain with radiation to the upper back. There was a complaint of low back pain with occasional radiation to bilateral lumbar extremity, left worse than right. He experienced bilateral foot pain, aggravated by walking. He reported symptoms of depression secondary to chronic pain. He likewise had headaches for 4 to 5 times per day, starting as sensitivity to light and then becoming dull, without relief from medications. Patient likewise reported sleeping for only 4 hours per night due to pain. Physical examination of the cervical spine showed muscle spasm, restricted motion and positive Spurling's sign to the left. Examination of the lumbar spine showed moderate muscle spasm, restricted motion, and positive straight leg raise test to the left. Gait was antalgic. There was moderate tenderness of the bilateral acromioclavicular region, both knees, parathoracic muscles, and MTP joints. Range of motion of both shoulders was limited on all planes. Bilateral knee range of motion was zero to 100 degrees. There was slight swelling of the left ankle. Range of motion of the ankle was limited. Patient's mood and affect were moderately depressed. MRI of the cervical spine, dated 7/17/2013, demonstrated mild posterior broad-based disk bulge at C3 to C4 interspace with mild anterior effacement of the spinal canal and mild right neural foramina stenosis without otherwise significant focal abnormality within the spinal cord itself. Treatment to date has included left ankle surgery in 2001, left knee arthroscopy in 2003, right knee

arthroscopy in 2011, Euflexxa injection, use of a TENS unit, knee brace, physical therapy, chiropractic care, and medications such as Zanaflex, Norco, Ibuprofen, Valium, Prilosec, and topical creams (all since February 2014). Utilization review from 8/8/2014 denied the request for physical therapy/chiro because of no documentation of flare up of chronic pain to warrant additional therapy sessions; denied massage because there should be an adjunct exercise; denied urology consult because there was no documentation of progressive neurologic deficits; denied bilateral knee care with [REDACTED] because of no indication that patient had exacerbation or progression of knee problems; denied periodic foot care with [REDACTED] because the request was not specific for speculative future medical care; denied Zanaflex 4 mg, quantity 30 because of no subjective complaints of muscle spasm; modified request for Norco 10/325, quantity 120 to quantity 90 for purpose of weaning because of no documentation of objective functional benefit; denied ibuprofen 800 mg, quantity number 90 because of long-term use was not recommended; modified request for Valium 2 mg, #30 into #15 for the purpose of weaning because long-term use was not recommended; denied Prilosec 20 mg, quantity number 60 because a simultaneous request for NSAID was not certified; and denied Menthoderm topical cream because of lack of published studies concerning its efficacy and safety.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy/Chiro (Unspecified): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy/Manual Therapy and Manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manipulation Therapy; Physical Medicine Page(s): 58-59; 98-99.

Decision rationale: As stated on pages 98-99 of the California MTUS Chronic Pain Medical Treatment Guidelines, physical medicine is recommended and that given frequency should be tapered and transition into a self-directed home program. As stated on pages 58-59 of CA MTUS Chronic Pain Medical Treatment Guidelines, several studies of manipulation have looked at duration of treatment, and they generally showed measured improvement within the first few weeks or 3-6 visits of chiropractic treatment, although improvement tapered off after the initial sessions. There should be some outward sign of subjective or objective improvement within the first 6 visits for continuing treatment. In this case, patient previously completed a course of physical therapy and chiropractic care. However, the patient's response to treatment was not discussed. There was no objective evidence of overall pain improvement and functional gains derived from the treatment. Given the duration of injury, it is unclear why patient is still not versed to home exercise program to address the residual deficits. Moreover, there were no recent reports of acute exacerbation or progression of symptoms that would warrant additional course of treatment. The medical necessity has not been established. Moreover, body part to be treated and number of sessions were not specified. Therefore, the request for Physical Therapy/Chiro (Unspecified) is not medically necessary.

Massage (Unspecified): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Massage Therapy Page(s): 60.

Decision rationale: According to page 60 of the CA MTUS Chronic Pain Medical Treatment Guidelines, massage therapy should be an adjunct to other recommended treatment (e.g. exercise), and it should be limited to 4-6 visits in most cases. Massage is a passive intervention and treatment dependence should be avoided. This lack of long-term benefits could be due to the short treatment period or treatments such as these do not address the underlying causes of pain. In this case, patient previously underwent massage therapy. However, there is no documentation concerning pain relief and functional improvement. Moreover, there is no evidence that patient is actively participating in an exercise program, since massage therapy is not recommended as a solitary treatment option. Moreover, body part to be treated and number of sessions were not specified. Therefore, the request for massage (unspecified) is not medically necessary.

Neurosurgical Consultation: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Chapter 7, Independent Medical Examinations and Consultations, page(s) 127

Decision rationale: As stated on page 127 of the California MTUS ACOEM Independent Medical Examinations and Consultations Chapter, occupational health practitioners may refer to other specialists if the diagnosis is uncertain, or when psychosocial factors are present. In this case, there is no clear rationale for a neurosurgical consultation. There is no discussion concerning treatment plan involving surgery. The body part to be consulted is likewise not indicated. There is no worsening of symptoms and physical exam findings or new imaging results to warrant specialist consultation. There is no clear indication for the requested service; therefore, the request for neurosurgical consultation is not medically necessary.

Periodic Bilateral Knee Care: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Section, Office Visits

Decision rationale: The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Official Disability Guidelines, (ODG), Pain Chapter was used instead. It states that evaluation and management (E&M) outpatient visits to the offices of medical doctor play a critical role in the proper diagnosis and return to function of an injured worker, to monitor the patient's progress, and make any necessary modifications to the treatment plan. In this case, patient complained of bilateral knee pain corroborated by tenderness, with a range of motion measured from zero to 100 degrees. Patient currently uses a knee brace. However, there is no clear indication for the request. The request is likewise nonspecific in terms of frequency of office visits necessary. It also does not indicate the specialization of the treating provider. Therefore, the request for periodic bilateral knee care is not medically necessary.

Periodic Foot Care: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Section, Office Visits

Decision rationale: The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Official Disability Guidelines, (ODG), Pain Chapter was used instead. It states that evaluation and management (E&M) outpatient visits to the offices of medical doctor play a critical role in the proper diagnosis and return to function of an injured worker, to monitor the patient's progress, and make any necessary modifications to the treatment plan. In this case, patient complained of bilateral foot pain, aggravated by walking. Physical examination showed swelling of the left ankle, limited motion of both ankle, and tenderness to MTP joints. However, there is no clear indication for the request. The request is likewise nonspecific in terms of frequency of office visits necessary. It also does not indicate the specialization of the treating provider. Therefore, the request for periodic foot care is not medically necessary.

Zanaflex 4 mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxant Page(s): 63.

Decision rationale: According to page 63 of the CA MTUS Chronic Pain Medical Treatment Guidelines, non-sedating muscle relaxants are recommended with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. In this case, the patient has been on tizanidine since February 2014. However, there is no documentation concerning pain relief and functional improvement derived from its use.

Although the most recent physical examination still showed evidence of muscle spasm, long-term use of relaxant is not recommended. Therefore, the request for Zanaflex 4mg, #30 is not medically necessary.

Prilosec 20 mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI Symptoms, and Cardiovascular Risk Page(s): 68.

Decision rationale: As stated on page 68 of CA MTUS Chronic Pain Medical Treatment Guidelines, clinicians should weigh the indications for NSAIDs against both GI and cardiovascular risk factors: age > 65 years, history of peptic ulcer, GI bleeding or perforation; concurrent use of ASA, corticosteroids, or anticoagulant; or on high-dose/multiple NSAIDs. Patients with intermediate risk factors should be prescribed proton pump inhibitors (PPI). In this case, patient has been on Prilosec since February 2014. However, there was no subjective report of heartburn, epigastric burning sensation or any other gastrointestinal symptoms that may corroborate the necessity of this medication. Furthermore, patient did not meet any of the aforementioned risk factors. The guideline criteria were not met. Therefore, the request for Prilosec 20 mg #60 is not medically necessary.

Menthoderm Topical Cream: 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 based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Section, Topical Salicylates

Decision rationale: Page 111 of CA MTUS Chronic Pain Medical Treatment Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Menthoderm gel contains methyl salicylate and menthol. Regarding the Menthol component, CA MTUS does not cite specific provisions, but the ODG Pain Chapter states that the FDA has issued an alert in 2012 indicating that topical OTC pain relievers that contain menthol, or methyl salicylate, may in rare instances cause serious burns. Regarding the Methyl Salicylate component, CA MTUS states on page 105 that salicylate topicals are significantly better than placebo in chronic pain. In this case, Menthoderm gel was prescribed as adjuvant therapy to oral medications. However, the requested Menthoderm has the same formulation of over-the-counter products such as BenGay. It has not been established that there is any necessity for this specific brand name. There is no compelling indication for this request. Therefore, the request for Menthoderm topical cream is not medically necessary.

Norco 10/325 mg #120: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: As stated on page 78 of CA MTUS Chronic Pain Medical Treatment Guidelines, there are 4 A's for ongoing monitoring of opioid use: pain relief, side effects, physical and psychosocial functioning and the occurrence of any potentially aberrant drug-related 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. In this case, patient has been on Norco since February 2014. However, the medical records do not clearly reflect continued analgesia, continued functional benefit, or a lack of adverse side effects. Urine drug screens were not available for review. MTUS Guidelines require clear and concise documentation for ongoing management. Therefore, the request for Norco 10/325 mg #120 is not medically necessary.

Valium 2 mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines. Decision based on Non-MTUS Citation Official Disability Guidelines, Benzodiazepines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: As stated on page 24 of CA MTUS Chronic Pain Medical Treatment Guidelines, benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence. Most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic benzodiazepines are the treatment of choice in very few conditions. In this case, patient has been on Valium since February 2014 for insomnia. However, there is no documentation concerning pain relief and functional improvement derived from its use. Furthermore, diazepam is not recommended for long-term use as stated by the guidelines. The medical necessity has not been established. Therefore, the request for Valium 2 mg #30 is not medically necessary.

Ibuprofen 800 mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory Medication.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 46.

Decision rationale: As stated on page 46 of the California MTUS Chronic Pain Medical Treatment guidelines, NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain and that there is no evidence of long-term effectiveness for pain or function. In this case, patient has been on ibuprofen since February 2014. However, there is no documentation concerning pain relief and functional improvement derived from its use. Long-term use is likewise not recommended. Therefore, the request for Ibuprofen 800 mg #90 is not medically necessary.