

Case Number:	CM14-0179837		
Date Assigned:	11/06/2014	Date of Injury:	02/28/2014
Decision Date:	12/17/2014	UR Denial Date:	10/01/2014
Priority:	Standard	Application Received:	10/29/2014

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 New Jersey. 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:

The worker is a 30 year old male who was injured on 2/26/2014. He was diagnosed with lumbar strain and lumbar radiculitis. He was treated with physical therapy, multiple oral and topical medications, shockwave and intense neurostimulation therapy, chiropractor treatments, and TENS unit. MRI of the lumbar spine was completed on 4/18/2014, showing L4-5 central disc protrusion and annular tear with mild canal stenosis and mild bilateral neuroforaminal narrowing, and also showed L5-S1 grade 1 retrolisthesis with mild bilateral neuroforaminal narrowing and a 3 mm left paracentral disc protrusion with annular tear impinging on the descending left S1 nerve root. On 9/17/2014, the worker was seen by his primary treating physician complaining of burning low back pain rated 7/10 on the pain scale and associated with numbness and tingling of the bilateral lower extremities and bowel and bladder problems all of which had been chronic for many months, but helped with the medications that he takes (not listed in the progress note). The medications also reportedly help him to sleep. No problems with the medications were reported. Physical findings included squatting limited due to pain, toe touch caused pain, tenderness noted at the paraspinal muscles over the lumbosacral junction, positive straight leg raise, slightly decreased sensation along L4, L5, and S1 dermatomes bilaterally, 4/5 strength in the lower extremities, and 2+ deep tendon reflexes in the lower extremities. He was then recommended to continue his previously used medications, continue physiotherapy with shock wave and intense neurostimulation, see a chiropractor, and see a pain specialist for consideration of an epidural steroid injection. A request was also made for approval of a lumbar MRI, X-ray of the lumbar spine, TENS, and a hot/cold device.

IMR ISSUES, DECISIONS AND RATIONALES

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

Office Consultation: Pain management consultation, qty. 1: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Page(s): 127, Chronic Pain Treatment Guidelines Opioids Page(s): 124, 77, 81.

Decision rationale: The MTUS/ACOEM Guidelines state that referral to a specialist(s) may be warranted if a diagnosis is uncertain, or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise in assessing therapeutic management, determination of medical stability, and permanent residual loss and/or examinee's fitness for return to work, and suggests that an independent assessment from a consultant may be useful in analyzing causation or when prognosis, degree of impairment, or work capacity requires clarification. Specifically with those taking opioids, a pain specialist may be helpful and warranted in cases where subjective complaints do not correlate with imaging studies and/or physical findings and/or when psychosocial issue concerns exist, when dosing of opioids begins to approach the maximum recommended amounts, or when weaning off of opioids proves to be challenging. In the case of this worker, referral to a pain specialist might provide additional options for treating his chronic low back pain with radiculopathy, namely epidural steroid injections, which was the intention of the requesting provider. Considering the extensive list of treatments the worker has trialed, referral to a Pain Specialist seems reasonable and medically necessary at this point in the worker's care.

Terocin Patches: Ketoprofen 20% cream, 165 grams; Cyclobenzaprine 5% cream, 100grams; Synapryn 10mg/1ml Oral Suspension 500ml: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm, Topical Analgesics, Lidocaine, Page(s): 112, 56-57.

Decision rationale: Terocin is a patch which included the active ingredients menthol and Lidocaine. The MTUS Guidelines for Chronic Pain state that topical Lidocaine is not a first-line therapy for chronic pain, but may be recommended for localized peripheral neuropathic pain after there has been evidence of a trial of first-line therapy (including tri-cyclic, SNRI anti-depressants, or an AED such as gabapentin or Lyrica). Topical Lidocaine is not recommended for non-neuropathic pain as studies showed no superiority over placebo. In the case of this worker, there is clear subjective and objective evidence for lumbar radiculopathy and the worker reportedly had been taking Gabapentin for some time (no report on effectiveness), therefore topical Lidocaine might be recommended for this worker. However, as the worker had been taking Terocin, there was insufficient documented evidence that it was independently improving the worker's function, which is required in order to justify continuation. Therefore, the Terocin

will be considered not medically necessary until documented evidence of functional benefit is present.

Unlisted Physical Medicine/ Rehabilitation Service or procedure: Localized intense Neurostimulation Therapy (1 x wk x 6wks): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back section, Hyperstimulation analgesia

Decision rationale: The MTUS does not address localized intense neurostimulation therapy (LINT) for low back pain. The ODG, however, states that hyper stimulation analgesia (such as LINT) is not recommended until there are higher quality studies to show efficacy and safety, although small manufacturer-funded studies suggest that this method is promising. In the case of this worker, he was recommended LINT for his low back pain. However, until this therapeutic modality has more data to confirm its effectiveness and safety, it will be considered not medically necessary.

X-Ray Exam of Lower Spine (Lumbar x-rays): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304.

Decision rationale: The MTUS ACOEM Guidelines state that lumbar spine x-rays should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least six weeks. However, it may be appropriate when the physician believes it would aid in patient management. In the case of this worker, there was no documented evidence to suggest a significant change in his symptoms that might have warranted lumbar x-rays. His MRI from months prior was sufficient enough to clarify the cause of his pain. Therefore, the lumbar X-rays are not medically necessary, unless a documented explanation reveals a logical reason to order this.

Transcutaneous Electrical Nerve Stimulation (TENS) Device, four or more Leads QTY: 1 TENS Unit (for home use): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy, TENS Page(s): 114-116.

Decision rationale: The MTUS Guidelines for Chronic Pain state that transcutaneous nerve stimulation (TENS) is not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a non-invasive conservative option, if used as an adjunct to a program of evidence-based functional restoration, however, the studies on TENS are inconclusive and evidence is lacking concerning effectiveness. The criteria for the use of TENS, according to the MTUS Guidelines, include 1. Documentation of pain of at least three months duration 2. Evidence that other appropriate pain modalities have been tried and failed 3. Documentation of other pain treatments during TENS trial 4. Documented treatment plan including the specific short and long-term goals of treatment with TENS 5. Documentation of reasoning for use of a 4-lead unit, if a 4-lead unit is prescribed over a 2-lead unit. The worker in this case had used TENS at the time of this request, however, it is not clear if this request is retrospective or for another TENS unit. Regardless, if this is for a retrospective request, there should have been a one month trial before considering purchase of a TENS unit, and if he had already trialed the TENS at home for one month, there is no documented evidence found in the notes available for review showing functional improvement with its use. Therefore, the TENS unit will be considered not medically necessary.

Durable Medical Equipment (DME) Hot/Cold Unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Lower Back section, Heat therapy

Decision rationale: The MTUS ACOEM Guidelines are not specific as to whether or not heat therapy is appropriate for long-term use, but does mention it as an acceptable and essentially harmless conservative method to treat acute low back pain, or any other muscle pain (typically up to 2 weeks). The ODG recommends heat therapy as an option for low back pain, as it has been shown to reduce pain (although small and short-term) and increase function, especially when used during exercise during recovery from musculoskeletal injuries. However, for this treatment method to be justified for continuation, the patient needs to exhibit or report improvements in function and pain-relief attributable to its use. In the case of this worker, there is no documented evidence which might suggest he needed a special device to apply heat or cold to his lower back. There are many alternative methods to applying heat which do not require a special device and should be used first. Therefore, the hot/cold unit is not medically necessary.

Unlisted Physical Medicine/Rehabilitation Service or Procedure: Shockwave therapy - up to 6 treatments: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back section, Shock wave therapy

Decision rationale: The MTUS is silent regarding shock wave therapy for low back pain. The ODG, however, states that it is not recommended due to the available evidence not supporting the effectiveness of ultrasound or shock wave for treating low back pain. In the case of this worker, who had underwent shock wave therapy for his lower back pain; there was not any documented evidence of functional benefit directly related to the shock wave therapy that might have allowed the reviewer to consider this case an exception to the guidelines. Therefore, it will be considered not medically necessary.

MRI Lumbar Spine w/o Dye QTY: 1 Lumbar MRI: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 296-310. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Lower Back section, MRI

Decision rationale: MTUS Guidelines for diagnostic considerations related to lower back pain or injury require that for MRI to be warranted there needs to be unequivocal objective clinical findings that identify specific nerve compromise on the neurological examination (such as sciatica) in situations where red flag diagnoses (cauda equina, infection, fracture, tumor, dissecting/ruptured aneurysm, etc.) are being considered, and only in those patients who would consider surgery as an option. In some situations where the patient has had prior surgery on the back, MRI may also be considered. The MTUS also states that if the straight-leg-raising test on examination is positive (if done correctly) it can be helpful at identifying irritation of lumbar nerve roots, but is subjective and can be confusing when the patient is having generalized pain that is increased by raising the leg. The Official Disability Guidelines (ODG) state that for uncomplicated low back pain with radiculopathy MRI is not recommended until after at least one month of conservative therapy and sooner if severe or progressive neurologic deficit is present. The ODG also states that repeat MRI should not be routinely recommended, and should only be reserved for significant changes in symptoms and/or findings suggestive of significant pathology. It is unclear, in the case of this worker, whether or not this MRI request is a retrospective for the MRI of the lumbar spine completed on 4/18/14 or if it is for a repeat MRI. Based on subjective and objective evidence found in the notes available for review, there was sufficient evidence to warrant MRI of the lumbar spine. However, a repeat MRI does not seem to be backed up by any evidence of significant change in the worker's symptoms or physical findings. Regardless, without a clear designation as to which MRI this request is, then it will be considered not medically necessary.

Tabradol 1mg/ml Oral Suspension 250ml: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints,Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines muscle relaxants Page(s): 63-66.

Decision rationale: Tabradol is as combination oral medication that includes a Cyclobenzaprine as the active ingredient. The MTUS Guidelines state that using muscle relaxants for muscle strain may be used as a second-line option for short-term treatment of acute exacerbations of chronic pain, but provides no benefit beyond NSAID use for pain and overall improvement, and are likely to cause unnecessary side effects. Efficacy appears to diminish over time, and prolonged use may lead to dependence. In the case of this worker, he had used this muscle relaxant chronically leading up to this request, which is not the recommended use of this medication. Also, there was no documented report showing evidence of functional benefit directly from its use, which might have allowed the reviewer to consider this case as an exception to the guidelines. Therefore, it will be considered not medically necessary.

Deprizine 15mg/ml oral suspesion 250ml: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints,Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69.

Decision rationale: Deprizine is an oral form of ranitidine, an H-2 blocker anti-acid medication. The MTUS Guidelines state that to warrant using a proton pump inhibitor (PPI) or an H-2 blocker in conjunction with an NSAID, the patient would need to display intermediate or high risk for developing a gastrointestinal event such as those older than 65 years old, those with a history of peptic ulcer, GI bleeding, or perforation, or those taking concurrently aspirin, corticosteroids, and/or an anticoagulant, or those taking a high dose or multiple NSAIDs. In the case of this worker, there was insufficient evidence to suggest he was at an elevated risk of a gastrointestinal event which might have warranted consideration of an H-2 blocker for regular use. Therefore, the Deprizine is not medically necessary to continue.

Dicopanl 5mg/ml Oral Suspension 150ml: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints,Chronic Pain Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medscape.com:
(<http://reference.medscape.com/drug/benadryl-nytol-diphenhydramine-343392>)

Decision rationale: Dicopanl is a combination drug product which includes the active ingredient diphenhydramine. Diphenhydramine is not discussed in the MTUS Guidelines.

Diphenhydramine is indicated for allergic reactions, insomnia, cough, motion sickness, and Parkinsonism. In the case of this worker, it appeared that Dicopanol was prescribed for insomnia, perhaps related to his chronic pain. However, there is no documented evidence of functional benefit reported in the notes available for review around the time of the request. Also, there is no evidence to suggest taking a proprietary combination product with diphenhydramine is better than diphenhydramine alone. Therefore, the Dicopanol is not medically necessary to continue.

Fanatrex 25mg/ml 420ml: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs Page(s): 16-22.

Decision rationale: The MTUS Guidelines state that antiepilepsy drugs (or anti-convulsant) are recommended as first line therapy for neuropathic pain as long as there is at least a 30% reduction in pain. If less than 30% reduction in pain is observed with use, then switching to another medication or combining with another agent is advised. Documentation of pain relief, improvement in function, and side effects is required for continual use. Preconception counseling is advised for women of childbearing years before use, and this must be documented. In the case of this worker, who clearly has lumbar radiculopathy based on subjective complaints, but also imaging and physical findings, which would have warranted a trial of first line therapies such as gabapentin, there is, however, no documented evidence that this particular medication independently improving the workers' overall function. Therefore, without evidence of benefit, the Fanatrex is not medically necessary to continue.