

Case Number:	CM14-0219276		
Date Assigned:	01/09/2015	Date of Injury:	02/07/2012
Decision Date:	03/18/2015	UR Denial Date:	12/08/2014
Priority:	Standard	Application Received:	12/31/2014

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. 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: Pennsylvania
 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 44 year old male, who sustained an industrial injury on 2/07/2012 when he was trying to remove a damaged bag of dog food stacked towards the bottom of the pallet. He was bending down while pulling and tugging at the bag, when he experienced a sharp pain in his abdomen, groin and left testicle. He reported pain in his neck and back as well as radiating pain from his groin down into his legs and feet. The diagnoses have included lumbar spine musculoligamentous sprain/strain, rule out herniated nucleus pulposus and annular tear, and sleep disorder. Treatment to date has included physical therapy, medications, acupuncture, modified work duties, injections and shockwave therapy. Multiple topical compounded creams were prescribed for months in 2014 including cyclobenzaprine cream. Work status is noted as not working, temporarily totally disabled, and the documentation notes that he has not worked since April 2012. An emergency department report from 6/18/14 at which time the injured worker was evaluated for lumbar strain included report of a lumbosacral spine x-ray that showed normal alignment, normal disc spaces, and no fractures. An MRI of the lumbar spine on 11/3/14 showed disc protrusions at L4-5 and L5-S1. Medications as of 11/7/14 included norco, motrin, zestril, aspirin, lipitor, and flexeril. Currently, the injured worker complains of frequent moderate to severe headaches, memory loss and speech impairment. He reports abdominal pain, frequent constipation, bloating and nausea secondary to medications, and sleep disturbance. He has continuous pain in the neck with pain radiating to the bilateral upper extremities. He has continuous pain in the bilateral wrists/hands, bilateral arms, bilateral shoulders, and lumbar and cervical spine. He has frequent groin pain. Objective physical examination revealed a normal

gait. He uses a cane for ambulation. Range of motion of the cervical spine is decreased, with diffuse tenderness of the trapezius and periscapular muscles bilaterally, and negative Spurling's test. There is diffuse tenderness and spasm at L3 -S1 with positive bilateral straight leg raise test. Sensory examination in the upper and lower extremities was intact in all dermatomes bilaterally. The physician documented that the x-force stimulator was prescribed in order to help the injured worker become independent and take a role in management of symptoms, with plan for it to be used several times a day for "upwards of a few months," as part of a functional restoration program. On 12/08/2014, Utilization Review non-certified prescriptions for Voltaren XR 100mg #30, Ultracet 37.5/325mg #60, Magnetic resonance imaging (MRI) of the cervical spine, x-ray of the cervical and lumbar spine, X force stimulator, and solar care FIR heating system, and modified requests for Flexeril 10mg from #90 to #20, and physical therapy from (3x4) to (3 x 2), noting the clinical information submitted for review fails to meet the evidence based guidelines for the requested services. The MTUS, ACOEM Guidelines and ODG were cited. On 12/31/2014, the injured worker submitted an application for Independent Medical Review (IMR) of Voltaren XR 100mg #30, Ultracet 37.5/325mg #60, magnetic resonance imaging (MRI) of the cervical spine, x-ray of the cervical and lumbar spine, X force stimulator, solar care FIR heating system, Flexeril 10mg #20 and physical therapy (2x3).

IMR ISSUES, DECISIONS AND RATIONALES

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

Voltaren XR 100mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines, Chronic Pain Treatment Guidelines p. 67-73.

Decision rationale: Per the MTUS, nonsteroidal anti-inflammatory drugs (NSAIDs) are recommended as a second line treatment after acetaminophen for treatment of acute exacerbations of chronic back pain. NSAIDs are noted to have adverse effects including gastrointestinal side effects and increased cardiovascular risk; besides these well-documented side effects of NSAIDs, NSAIDs have been shown to possibly delay and hamper healing in all the soft tissues including muscles, ligaments, tendons, and cartilage. NSAIDs can increase blood pressure and may cause fluid retention, edema, and congestive heart failure; all NSAIDs are relatively contraindicated in patients with renal insufficiency, congestive heart failure, or volume excess. They are recommended at the lowest dose for the shortest possible period in patients with moderate to severe pain. The MTUS does not recommend chronic NSAIDs for low back pain, NSAIDs should be used for the short term only. Systemic toxicity is possible with NSAIDs. The FDA and MTUS recommend monitoring of blood tests and blood pressure. The documentation indicates that the injured worker had been previously prescribed motrin, another nonsteroidal, without documentation of functional improvement as a result of its use. Another physician was noted to be administering medication for blood pressure, and the injured worker's medications included zestril, an antihypertensive medication, although some progress notes document no known history of hypertension. There is no evidence that the prescribing physician

is adequately monitoring for toxicity as recommended by the FDA and MTUS. As the injured worker has been treated with NSAIDs for a longer term than is recommended by the guidelines, and due to the potential for toxicity in light of history of blood pressure issues, the request for voltaren is not medically necessary.

Ultracet 37.5/325mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines therapeutic trial of opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines opioids: tramadol Page(s): p. 93-94.

Decision rationale: Ultracet contains tramadol and acetaminophen. Tramadol is a centrally acting synthetic opioid analgesic which is not recommended as a first line oral analgesic. Multiple side effects have been reported including increased risk of seizure especially in patients taking selective serotonin reuptake inhibitors (SSRIs), tricyclic antidepressants (TCAs) and other opioids. It may also produce life-threatening serotonin syndrome. The injured worker has also been prescribed norco, another opioid, which also contains acetaminophen. There is no evidence that the treating physician is prescribing opioids according to the MTUS, which recommends prescribing according to function, with specific functional goals, return to work, random drug testing, and opioid contract. One urine drug screen was included in the documentation submitted, but there was no discussion of functional goals, opioid contract, or return to work. Work status continued to be temporarily totally disabled, which fails the return-to-work criterion for opioids, and represents an inadequate focus on functional improvement. Due to the lack of prescribing in accordance with the MTUS guidelines for opioid use, and the potential for toxicity in combination with norco, the request for ultracet is not medically necessary.

Flexeril 10mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines muscle relaxants. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines flexeril p. 41-42, muscle relaxants p. 63-66 Page(s): p. 41-42, 63-66.

Decision rationale: The MTUS for chronic pain does not recommend muscle relaxants for chronic pain. Non-sedating muscle relaxants are an option for short-term exacerbations of chronic low back pain. The muscle relaxant prescribed in this case is sedating. The injured worker has chronic pain with no evidence of prescribing for flare-ups. Prescribing has occurred consistently for months at minimum with cyclobenzaprine in topical form. The quantity prescribed implies long term use, not for a short period of use for acute pain. No reports show any specific and significant improvement in pain or function as a result of prescribing muscle relaxants. Per the MTUS chronic pain medical treatment guidelines, cyclobenzaprine (Flexeril, fexmid) is a skeletal muscle relaxant and a central nervous system depressant. It is recommended

as an option for a short course of therapy, with greatest effect in the first four days of treatment. Guidelines state that treatment should be brief. The addition of cyclobenzaprine to other agents is not recommended. Limited, mixed evidence does not allow for a recommendation for chronic use. Due to the quantity requested in excess of what is recommended by the guidelines, and lack of functional improvement as a result of prior use of the same medication in topical form, the request for flexeril is not medically necessary.

Physical therapy 3 times a week for 2 weeks -cervical: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper back procedure, Low back procedure

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): p.174, Chronic Pain Treatment Guidelines physical medicine Page(s): p. 98-99. Decision based on Non-MTUS Citation neck and upper back chapter: physical therapy

Decision rationale: The ACOEM neck and upper back chapter recommends 1-2 physical therapy visits for education, counselling, and evaluation of home exercise. The ODG states that physical therapy is recommended for a total of 9 visits over 8 weeks for cervicgia (neck pain) and cervical spondylosis, and 10 visits for sprains and strains of neck and displacement or degeneration of cervical intervertebral disc, with assessment after a six visit clinical trial. The ODG also recommends allowance for fading of treatment frequency from up to 3 visits per week to 1 or less plus active self-directed home therapy. The use of active treatment instead of passive modalities is noted to be associated with substantially better clinical outcomes. The records do not contain a sufficient prescription from the treating physician, which must contain diagnosis, duration, frequency, and treatment modalities, at a minimum. Although the progress notes document neck pain with cervical muscle spasm, no specific diagnosis related to the cervical spine was documented. Reliance on passive care is not recommended. The physical medication prescription is not sufficiently specific, and does not adequately focus on functional improvement. No functional goals were discussed. Per the MTUS chronic pain section, functional improvement is the goal rather than the elimination of pain. The number of sessions requested is in excess of the ACOEM guidelines for neck and upper back complaints. Although the ODG allows for a 6 visit clinical trial of physical therapy for certain diagnoses related to the cervical spine, the specific diagnosis was not provided, and the modalities to be utilized during therapy were not specified. Due to lack of specific indication and sufficiently specific prescription, and a number of sessions requested in excess of the ACOEM guidelines, the request for physical therapy to the cervical spine is not medically necessary.

MRI-cervical: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 172. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and upper back procedure

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): p. 170-172, 177-179.

Decision rationale: Per the MTUS/ACOEM, for most patients presenting with neck problems, special studies are not needed unless a 3-4 week period of conservative care and observation fails to improve symptoms. Criteria for ordering imaging studies include emergence of a red flag, or physiologic evidence of tissue insult or neurologic dysfunction. Physiologic evidence may be in the form of neurologic findings on physical examination and electrodiagnostic studies. In this case, a specific diagnosis related to the cervical spine was not documented. The physician noted cervical paraspinal muscle spasm and decreased range of motion, but noted normal sensory and motor examination of the upper extremities and negative Spurling's test. There were no red flag signs or symptoms, or evidence of soft tissue insult or neurologic dysfunction. For these reasons, the request for MRI of the cervical spine is not medically necessary.

X-ray for the cervical and lumbar: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 182. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper back procedure, low back procedure

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): chapter 8 p. 177-179, chapter 12 p. 296, 303.

Decision rationale: The ACOEM neck and upper back chapter states that for most patients presenting with neck or upper back problems, special studies are not needed unless a 3-4 week period of conservative care and observation fails to improve symptoms. Criteria for ordering imaging studies include emergence of a red flag, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery, and clarification of anatomy prior to an invasive procedure. Cervical radiographs are noted to be most appropriate for patients with acute trauma associated with midline vertebral tenderness, head injury, drug or alcohol intoxication, or neurologic compromise. In this case, none of these findings were present. Examination showed normal sensory and motor findings in the upper extremities, and negative Spurling's test. There was no history of trauma and no evidence of neurologic compromise. The ACOEM low back chapter notes that for acute lumbar strain, no tests are indicated for 4-6 weeks; for lumbosacral nerve root compression with radiculopathy, no tests are indicated for 4-6 weeks unless compression is severe or progressive. 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, but may be appropriate when the physician believes it would aid in pain management. There was no documentation of progressive symptoms. The injured worker had lumbar spine x-rays recently, in June 2014, without documentation of change in symptoms or findings since the x-rays were obtained, and a MRI of the lumbar spine was performed in November of 2014. Due to lack of indications, the requests for cervical and lumbar spine x-rays are not medically necessary.

x force stimulator purchase: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrical Nerve Stimulation (TENS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines transcutaneous electrotherapy Page(s): p. 114-121.

Decision rationale: An X-force stimulator unit is a proprietary device that delivers electrical impulses to a joint; it is a dual modality unit offering transcutaneous electrical joint stimulation (TEJS) and transcutaneous electrical nerve stimulation (TENS) functions. Electrotherapy represents the therapeutic use of electricity and is a modality that can be used in the treatment of chronic pain. Transcutaneous electrical nerve stimulation (TENS) devices are the most commonly used; other devices are distinguished from TENS based on their electrical specifications. The MTUS specifies that TENS is not recommended as a primary modality but a one-month home based TENS trial may be considered if used as an adjunct to a program of evidence based functional restoration for certain conditions, including neuropathic pain, complex regional pain syndrome, phantom limb pain, spasticity in spinal cord injury, multiple sclerosis, and acute post-operative pain. The injured worker's diagnoses included lumbar spine musculoligamentous sprain/strain, rule out herniated nucleus pulposus and annular tear, and sleep disorder. A treatment plan with the specific short and long term goals of treatment with the TENS unit should be submitted. The physician documented that the x-force stimulator was prescribed in order to help the injured worker become independent and take a role in management of symptoms, with plan for it to be used several times a day for "upwards of a few months," as part of a functional restoration program. The specific components and goals of a functional restoration program were not documented. Indications for transcutaneous electrical joint stimulation (TEJS) were not discussed, joint pain was not documented, and the MTUS does not note any conditions for which electrical joint stimulation would be indicated. Due to lack of indication and lack of goals of treatment, the request for x-force stimulator purchase is not medically necessary.

Solar care FIR heating system purchase: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 181. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), neck and upper back procedure , low back procedure

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): p. 299, 308. Decision based on Non-MTUS Citation low back chapter: heat therapy

Decision rationale: A solar care FIR heating system provides targeted infrared heat to areas of the body via application of wraps. Per the ACOEM low back chapter, at-home applications of heat or cold may be used for symptom control for low back complaints. Per the ODG, heat therapy is recommended as an option for treating low back pain. Both the MTUS and ODG recommend at-home local applications of cold packs in the first few days of acute complaint and thereafter applications of heat packs or cold packs. There is no recommendation for any specific

device in order to accomplish this. There was lack of documentation to indicate the frequency of use of the device, and no end point to use was specified. In addition, there was no documentation as to why at-home application of hot packs would be insufficient. For these reasons, the request for solar care FIR heating system unit is not medically necessary.