

<b>Case Number:</b>	CM15-0117386		
<b>Date Assigned:</b>	06/25/2015	<b>Date of Injury:</b>	03/27/2013
<b>Decision Date:</b>	08/26/2015	<b>UR Denial Date:</b>	05/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/17/2015

### 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: California, District of Columbia, Maryland  
 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 is a 40 year old female, who sustained an industrial injury on 3/27/2013. The injured worker was diagnosed as having bilateral knee chondromalacia patella, right ankle sprain /strain, and status post right ankle arthroscopy. Treatment to date has included diagnostics, right ankle surgery, unspecified physical therapy, transcutaneous electrical nerve stimulation unit, and medications. Currently (5/12/2015), the injured worker complains of right knee pain rated 6/10, left knee pain rated 3/10, and right ankle pain rated 5/10, status post right ankle arthroscopy in 7/2014. Medications facilitated maintenance activities of daily living and reduced pain. Nonsteroidal anti-inflammatory drug use improved range of motion and reduced pain by 3-4 points. She recalled a history of gastrointestinal upset with nonsteroidal anti-inflammatory drug use, without proton pump inhibitor use, noting failed first line proton pump inhibitor use. Refractory spasm prior to Cyclobenzaprine was noted. This use also decreased spasm and decreased pain by 3-4 points. The treatment plan included continued physical therapy (3x4) for the right knee and ankle and dispensed medications, Naproxen, Pantoprazole, and Cyclobenzaprine. On 4/07/2015, her pain levels were unchanged and Tramadol ER was noted to decrease pain by 5 points. Medication use included Naproxen, Pantoprazole, and Cyclobenzaprine (dispensed). Also requested was physical therapy. Medications appeared consistent, with no significant changes in pain or function, for several months. Urine toxicology reports were not submitted for review. Her work status was permanent and stationary and she was not working.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy 12 sessions, 3 times a week for 4 weeks, right knee and ankle: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Ankle & Foot, Physical Therapy.

**Decision rationale:** Per MTUS CPMTG, physical medicine guidelines state: 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 (ICD 729.2): 8-10 visits over 4 weeks. The ODG Preface specifies Physical Therapy Guidelines, "There are a number of overall physical therapy philosophies that may not be specifically mentioned within each guideline: (1) As time goes by, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency; (2) The exclusive use of "passive care" (e.g., palliative modalities) is not recommended; (3) Home programs should be initiated with the first therapy session and must include ongoing assessments of compliance as well as upgrades to the program; (4) Use of self-directed home therapy will facilitate the fading of treatment frequency, from several visits per week at the initiation of therapy to much less towards the end; (5) Patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy); & (6) When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted." Per the ODG guidelines: Ankle/foot Sprain (ICD9 845): Medical treatment: 9 visits over 8 weeks Post-surgical treatment: 34 visits over 16 weeks. Per the documentation submitted for review, the injured worker underwent right ankle surgery 7/2014. It stated that treatment included physical therapy, however, the number of sessions and the response to treatment was not documented. Absent such, the medical necessity of further sessions cannot be affirmed.

**Naproxen sodium 550 mg thrice daily #90 (DOS: 4/7/15): Upheld**

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

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

**Decision rationale:** With regard to the use of NSAIDs for chronic low back pain, the MTUS CPMTG states "Recommended as an option for short-term symptomatic relief. A Cochrane review of the literature on drug relief for low back pain (LBP) suggested that NSAIDs were no more effective than other drugs such as acetaminophen, narcotic analgesics, and muscle

relaxants. The review also found that NSAIDs had more adverse effects than placebo and acetaminophen but fewer effects than muscle relaxants and narcotic analgesics. In addition, evidence from the review suggested that no one NSAID, including COX-2 inhibitors, was clearly more effective than another." "Low back pain (chronic): Both acetaminophen and NSAIDs have been recommended as first line therapy for low back pain. There is insufficient evidence to recommend one medication over the other. Selection should be made on a case-by-case basis based on weighing efficacy vs. side effect profile." The documentation submitted for review indicates that the injured worker has using this medication daily, since 2014. As it is only recommended for short-term symptomatic relief, the request is not medically necessary.

**Pantoprazole 20 mg thrice daily #90 (DOS:4/7/15): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms and cardiovascular risks.

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

**Decision rationale:** In the treatment of dyspepsia secondary to NSAID therapy, the MTUS recommends stopping the NSAID, switching to a different NSAID, or considering the use of an H2-receptor antagonist or a PPI. The MTUS Chronic Pain Medical Treatment Guidelines recommend the use of proton pump inhibitors in conjunction with NSAIDs in situations in which the patient is at risk for gastrointestinal events including: (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). CPMTG guidelines further specify: "Recommendations: Patients with no risk factor and no cardiovascular disease: Non-selective NSAIDs OK (e.g, ibuprofen, naproxen, etc.)Patients 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 (200 mg 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). Patients at high risk for gastrointestinal events with no cardiovascular disease: A Cox-2 selective agent plus a PPI if absolutely necessary. Patients 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. (Laine, 2006) (Scholmerich, 2006) (Nielsen, 2006) (Chan, 2004) (Gold, 2007) (Laine, 2007)" As there NSAID therapy is not medically necessary, and there is no documentation of peptic ulcer, GI bleeding or perforation, or cardiovascular disease in the records available for my review, the injured worker's risk for gastrointestinal events is low, as such, medical necessity cannot be affirmed.

**Cyclobenzaprine 7.5 mg thrice daily as needed #90 (DOS 4/7/15): 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 relaxants Page(s): 63-64.

**Decision rationale:** With regard to muscle relaxants, the MTUS CPMTG states: "Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. (Chou, 2007) (Mens, 2005) (Van Tulder, 1998) (van Tulder, 2003) (van Tulder, 2006) (Schnitzer, 2004) (See, 2008) Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement." Regarding Cyclobenzaprine: "Recommended for a short course of therapy. Limited, mixed-evidence does not allow for a recommendation for chronic use. Cyclobenzaprine is a skeletal muscle relaxant and a central nervous system depressant with similar effects to tricyclic antidepressants (e.g. amitriptyline). Cyclobenzaprine is more effective than placebo in the management of back pain, although the effect is modest and comes at the price of adverse effects." Per p41 of the MTUS guidelines the effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. Treatment is recommended for the treatment of acute spasm limited to a maximum of 2-3 weeks. UDS that evaluate for cyclobenzaprine can provide additional data on whether the injured worker is compliant, however in this case there is no UDS testing for cyclobenzaprine. The documentation submitted for review indicates that the injured worker has been using this medication since at least 11/2014. As it is recommended only for short-term use, medical necessity cannot be affirmed.