

Case Number:	CM15-0125307		
Date Assigned:	07/09/2015	Date of Injury:	02/12/2009
Decision Date:	09/16/2015	UR Denial Date:	06/12/2015
Priority:	Standard	Application Received:	06/29/2015

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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive 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 57 year old female, who sustained an industrial injury on 2/12/09. Initial complaints were not reviewed. The injured worker was diagnosed as having neural encroachment L4-5; right shoulder impingement; right wrist/hand pain; right knee pain. Treatment to date has included status post right wrist carpal tunnel release (7/27/11); status post right shoulder arthroscopy (7/1/09); SIJ injection; epidural steroid injection lumbar spine (2010); TENS unit; back brace; acupuncture; urine drug testing; physical therapy; medications. Diagnostics studies included MRI right shoulder (2009); MRI lumbar spine (2014); EMG/NCV study (2014). Currently, the PR-2 notes dated 5/6/15 indicated the injured worker complains of low back pain with increased right greater than left lower extremity symptoms rating this pain at 7/10. She reports a flare-up due to travel for a psychiatric AME. Pain is rated as 5/10 for right shoulder pain; 5/10 for the right wrist/hand pain; 5/10 for the right knee pain and right elbow pain is rated as 5/10. Her medications were documented as Cyclobenzaprine 10mg three times a day, Tramadol 50mg twice a day and Lidoderm patches. She reports a successful trial of the topical antiepileptic drug, a five point diminution of lumbar radicular pain component with improved tolerance to standing and walking and desires to continue this topical medication. She reports she failed the oral antiepileptic drug due to GI upset and lethargy. The lumbar range of motion percent is normal with flexion 50, extension 40, left and right lateral tilt 40, left rotation 40. She has positive straight leg raise right for pain to the foot at 35 degrees and left for pain to the distal calf at 40 degrees. The provider documents he wants her to continue the LSO brace and TENS unit. The provider is requesting authorization of Chiropractic therapy for the lumbar spine

12 sessions; Compound: Ketoprofen 10%, Gabapentin 6%, Bupivacaine HCL 5%, Baclofen 2%, Cyclobenzaprine HCL 2%, Clonidine HCL 0.2%, Sodium hyaluronate 0.2%; Cyclobenzaprine 10mg #90; Lidoderm patches and Tramadol 50mg #60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic treatment, lumbar spine 3 x 4: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-60. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Chiropractic, Manipulation.

Decision rationale: ODG recommends chiropractic treatment as an option for acute low back pain, but additionally clarifies that "medical evidence shows good outcomes from the use of manipulation in acute low back pain without radiculopathy (but also not necessarily any better than outcomes from other recommended treatments). If manipulation has not resulted in functional improvement in the first one or two weeks, it should be stopped and the patient reevaluated." Additionally, MTUS states "Low back: Recommended as an option. Therapeutic care" Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. Elective "maintenance care "not medically necessary. Recurrences / flare-ups "Need to reevaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months." Medical documents indicate that patient has undergone previous chiropractic sessions. The treating provider has not demonstrated evidence of objective and measurable functional improvement during or after the trial of therapeutic care to warrant continued treatment. As such, the request for Chiropractic treatment, lumbar spine 3 x 4 is not medically necessary.

Compound: Ketoprofen 10%, Gabapentin 6%, Bupivacaine HCL 5%, Baclofen 2%, Cyclobenzaprine HCL 2%, Clonidine HCL 0.2%, Sodium hyaluronate 0.2%: 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, Compound creams.

Decision rationale: MTUS and ODG recommends usage of topical analgesics as an option, but also further details "primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed." The medical documents do not indicate failure of antidepressants or anticonvulsants. MTUS states, "There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." MTUS states that topical Baclofen is "Not recommended." MTUS states regarding topical muscle relaxants, "Other muscle relaxants: There is no evidence for use of any other muscle relaxant as a topical product."

Topical cyclobenzaprine is not indicated for this usage, per MTUS. As such, the request for Compound: Ketoprofen 10%, Gabapentin 6%, Bupivacaine HCL 5%, Baclofen 2%, Cyclobenzaprine HCL 2%, Clonidine HCL 0.2%, Sodium hyaluronate 0.2% is not medically necessary.

Cyclobenzaprine 10mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine, Medications for chronic pain, Antispasmodics Page(s): 41-42, 60-61, 64-66. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Cyclobenzaprine (Flexeril®) and Other Medical Treatment Guidelines UpToDate, Flexeril.

Decision rationale: MTUS Chronic Pain Medical Treatment states for Cyclobenzaprine, "Recommended as an option, using a short course of therapy. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. (Browning, 2001) Treatment should be brief." "The medication is not recommended to be used for longer than 2-3 weeks." The medical documents indicate that patient is far in excess of the initial treatment window and period. Additionally, MTUS outlines that "Relief of pain with the use of medications is generally temporary, and measures of the lasting benefit from this modality should include evaluating the effect of pain relief in relationship to improvements in function and increased activity. Before prescribing any medication for pain the following should occur: (1) determine the aim of use of the medication; (2) determine the potential benefits and adverse effects; (3) determine the patient's preference. Only one medication should be given at a time, and interventions that are active and passive should remain unchanged at the time of the medication change. A trial should be given for each individual medication. Analgesic medications should show effects within 1 to 3 days, and the analgesic effect of antidepressants should occur within 1 week. A record of pain and function with the medication should be recorded. (Mens, 2005) Uptodate "Flexeril" also recommends, "Do not use longer than 2-3 weeks". Medical documents do not fully detail the components outlined in the guidelines above and do not establish the need for long term/chronic usage of cyclobenzaprine. ODG states regarding cyclobenzaprine, "Recommended as an option, using a short course of therapy. The addition of cyclobenzaprine to other agents is not recommended." Several other pain medications are being requested, along with cyclobenzaprine, which ODG recommends against. As such, the request for Cyclobenzaprine 10mg #90 is not medically necessary.

Tramadol 50mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Tramadol, Ultram Page(s): 74-96, 113, 123. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) - Medications for acute pain (analgesics), Tramadol (Ultram®).

Decision rationale: Tramadol is classified as a central acting synthetic opioids. MTUS states regarding Tramadol that "A therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Before initiating therapy, the patient should set goals,

and the continued use of opioids should be contingent on meeting these goals." ODG further states, "Tramadol is not recommended as a first-line oral analgesic because of its inferior efficacy to a combination of Hydrocodone/ acetaminophen." The treating physician did not provide sufficient documentation that the patient has failed a trial of non-opioid analgesics at the time of prescription or in subsequent medical notes. Additionally, no documentation was provided which discussed the setting of goals for the use of Tramadol prior to the initiation of this medication. MTUS states that "ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life." The treating physician does not fully document the least reported pain over the period since last assessment, intensity of pain after taking opioid, pain relief, increased level of function, or improved quality of life. As such, the request for Tramadol 50mg #60 is not medically necessary.

Lidoderm patches: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm patches Page(s): 56-57. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Topical analgesics and Other Medical Treatment Guidelines UpToDate.com, Lidocaine (topical).

Decision rationale: Chronic Pain Medical Treatment Guidelines state "Lidoderm is the brand name for a lidocaine patch produced by [REDACTED]. Topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). This is not a first-line treatment and is only FDA approved for post-herpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. Formulations that do not involve a dermal-patch system are generally indicated as local anesthetics and anti-pruritics. For more information and references, see Topical analgesics." ODG further details, "Criteria for use of Lidoderm patches: (a) Recommended for a trial if there is evidence of localized pain that is consistent with a neuropathic etiology. (b) There should be evidence of a trial of first-line neuropathy medications (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). (c) This medication is not generally recommended for treatment of osteoarthritis or treatment of myofascial pain/trigger points. (d) An attempt to determine a neuropathic component of pain should be made if the plan is to apply this medication to areas of pain that are generally secondary to non-neuropathic mechanisms (such as the knee or isolated axial low back pain). One recognized method of testing is the use of the Neuropathic Pain Scale. (e) The area for treatment should be designated as well as number of planned patches and duration for use (number of hours per day). (f) A Trial of patch treatment is recommended for a short-term period (no more than four weeks). (g) It is generally recommended that no other medication changes be made during the trial period. (h) Outcomes should be reported at the end of the trial including improvements in pain and function, and decrease in the use of other medications. If improvements cannot be determined, the medication should be discontinued. (i) Continued outcomes should be intermittently measured and if improvement does not continue, lidocaine

patches should be discontinued." Medical documents provided do not indicate that the use would be for post-herpetic neuralgia. Additionally, treatment notes did not detail other first-line therapy used and what the clinical outcomes resulted. As such, the request for Lidoderm patches is not medically necessary.