

<b>Case Number:</b>	CM15-0127847		
<b>Date Assigned:</b>	07/14/2015	<b>Date of Injury:</b>	09/03/2010
<b>Decision Date:</b>	09/18/2015	<b>UR Denial Date:</b>	05/29/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/02/2015

### 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 55-year-old female who sustained an industrial injury on September 3, 2010. She has reported severe neck pain radiates to the right arm, severe low back pain, left shoulder and right shoulder pain, and right wrist pain. Diagnoses included cervical spine sprain strain and degenerative disc disease, lumbar sprain strain and degenerative disc disease, left shoulder impingement, right wrist sprain strain, carpal tunnel syndrome right and left, right shoulder strain and increased pain subsequent to a fall. Treatment has included medications and massage therapy. Cervical spine reveals spasm. Range of motion was painful and decreased. There was tenderness to palpation over the cervical spine. Examination of the right wrist revealed a positive de Quervain. Examination of the shoulders revealed a positive impingement sign bilaterally. Range of motion was painful on both sides. There was tenderness to palpation. Exam of the lumbar spine revealed painful and limited range of motion. Straight leg raise was positive at 60 degrees bilaterally. Pain was present at L5-S1. The treatment request included physical therapy, massage therapy, Norco, flexeril, and biofreeze cream.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PT 2x6:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 65-194, Chronic Pain Treatment Guidelines Physical Therapy, Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Neck and Upper Back, Physical Therapy, ODG Preface - Physical Therapy.

**Decision rationale:** MTUS refer to physical medicine guidelines for physical therapy and recommends as follows: "Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." Additionally, ACOEM guidelines advise against passive modalities by a therapist unless exercises are to be carried out at home by patient. ODG writes regarding neck and upper back physical therapy, "Recommended - Low stress aerobic activities and stretching exercises can be initiated at home and supported by a physical therapy provider, to avoid debilitation and further restriction of motion." ODG further quantifies its cervical recommendations with Cervicalgia (neck pain); Cervical spondylosis = 9 visits over 8 weeks. Sprains and strains of neck = 10 visits over 8 weeks. Regarding physical therapy, ODG states "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." At the conclusion of this trial, additional treatment would be assessed based upon documented objective, functional improvement, and appropriate goals for the additional treatment. The request for 12 sessions of physical therapy is in excess of guideline recommendations for treatment of chronic cervical pain. Additionally, the treating physician has not provided documentation of objective functional improvement with prior physical therapy. The treating physician does not detail extenuating circumstances that would warrant exception to the guidelines. As such, the request for PT 2x6 is not medically necessary.

**Massage Therapy 2x6:** 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 based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Massage Therapy, Manual Therapy.

**Decision rationale:** MTUS states regarding massage therapy, recommended as an option as indicated below: This treatment should be an adjunct to other recommended treatment (e.g. exercise), and it should be limited to 4-6 visits in most cases. ODG offers additional frequency and timeline for massage therapy by recommending: a. Time to produce effect: 4 to 6 treatments. b. Frequency: 1 to 2 times per week for the first 2 weeks as indicated by the severity of the condition. Treatment may continue at 1 treatment per week for the next 6 weeks. c. Maximum duration: 8 weeks. At week 8, patients should be reevaluated. Care beyond 8 weeks may be indicated for certain chronic pain patients in whom manipulation is helpful in improving function, decreasing pain and improving quality of life. The request is in excess of the guidelines recommendation of 4-6 visits over no more than 8 week. Medical documents do not indicate reasons for treatment in excess of the 8-week maximum without. As such, the request for Massage Therapy 2x6 is not medically necessary at this time.

**Norco 10/325 MG Qty 180:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute and Chronic), Low Back - Lumbar & Thoracic (Acute & Chronic), Opioids, Pain.

**Decision rationale:** ODG does not recommend the use of opioids for neck and low back pain except for short use for severe cases, not to exceed 2 weeks. The patient has exceeded the 2 week recommended treatment length for opioid usage. MTUS does not discourage use of opioids past 2 weeks, but does state 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 intensity of pain after taking opioid, pain relief, increased level of function, or improved quality of life. As such, the request for Norco 10/325 MG Qty 180 is not medically necessary.

**Flexeril 7.5 MG Qty 120:** Upheld

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

**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 Up-To-Date, 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) Up-to-date "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 Flexeril 7.5 MG Qty 120 is not medically necessary.

**Biofreeze 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 (Chronic) and Low Back, Topical Analgesics and Biofreeze.

**Decision rationale:** Biofreeze is a compound topical analgesic containing camphor and menthol. ODG recommends usage of topical analgesics as an option, but also further details primarily recommended for neuropathic pain when trials of antidepressants and anti-convulsants have failed. The medical documents do not indicate failure of antidepressants or anti-convulsants. 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." ACOEM and MTUS are silent regarding the use of camphor. ODG states in the low back chapter regarding biofreeze, recommended as an optional form of cryotherapy for acute pain. See also Cryotherapy, Cold/heat packs. Biofreeze is a nonprescription topical cooling agent with the active ingredient menthol that takes the place of ice packs. Whereas ice packs only work for a limited period of time, Biofreeze can last much longer before reapplication. This randomized controlled study designed to determine the pain-relieving effect of Biofreeze on acute low back pain concluded that significant pain reduction was found after each week of treatment in the experimental group. (Zhang, 2008) Medical documents do not indicate that the Biofreeze is to be used for acute low back pain, which is indicated per ODG. As such, the request for Biofreeze Cream is not medically necessary.