

Case Number:	CM15-0093938		
Date Assigned:	07/06/2015	Date of Injury:	02/09/2015
Decision Date:	08/25/2015	UR Denial Date:	04/27/2015
Priority:	Standard	Application Received:	05/15/2015

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

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 48 year old female, who sustained an industrial injury on 2/9/15. She reported pain in her back and right shoulder related to repetitive motions. The injured worker was diagnosed as having lumbar disc disease, lumbar Radiculopathy and lumbar facet syndrome. Treatment to date has included a lumbar MRI on 3/17/15 showing a 4mm disc protrusion at L5- S1 and Tylenol. As of the PR2 dated 4/2/15, the injured worker reports pain in her lower back and right shoulder. Objective findings include a positive straight leg raise test bilaterally, a negative Patrick's test and moderate lumbar facet pain over the L5-S1 facets. The treating physician requested Flexeril 7.5mg #60, Amitriptyline 4%, Baclofen 4%, Gabapentin 5%, Cyclobenzaprine 2%, Flurbiprofen 10%, Clondine 0.2%, BUpivacaine 2%, 180 grams, an IF unit 30 day trial for home use and bilateral L5-S1 and left S1 transforaminal epidural steroid injection x 2.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flexeril 7.5mg, #60: Upheld

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

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

Decision rationale: The patient was injured on 02/09/15 and presents with pain in the lumbar spine. The request is for FLEXERIL 7.5 MG #60. The RFA is dated 04/20/15 and the patient's work status is not provided. There is no indication of when the patient began taking this medication. MTUS, pages 63-66, states: Muscle relaxants (for pain): Recommended non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. The most commonly prescribed antispasmodic agents are Carisoprodol, Cyclobenzaprine, Metaxalone, and Methocarbamol, but despite the popularity, skeletal muscle relaxants should not be the primary drug class of choice for musculoskeletal conditions. Cyclobenzaprine (Flexeril, Amrix, Fexmid, generic available): Recommended for a short course of therapy. The patient is diagnosed with lumbar disc disease, lumbar Radiculopathy, and lumbar facet syndrome. She has an antalgic gait on the left, has diffuse lumbar paraspinous muscle tenderness, moderate lumbar facet pain over L5-S1 facets, and decreased sensation in the L5 dermatome on the right and L5/S1 dermatome on the left. MTUS Guidelines do not recommend the use of Cyclobenzaprine for longer than 2-3 weeks. There is no indication that the patient will be using this medication on a short term basis. It is unknown when the patient began taking this medication and an additional 60 tablets of Flexeril may exceed the 2-3 weeks recommended by MTUS guidelines. Therefore, the requested Flexeril IS NOT medically necessary.

Amitriptyline 4%, Baclofen 4%, Gabapentin 5%, Cyclobenzaprine 2%, Flurbiprofen 10%, Clondine 0.2%, Bupivacaine 2%, 180 grams: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Page(s): 111, 112-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Topical analgesics Page(s): 111.

Decision rationale: The patient was injured on 02/09/15 and presents with pain in the lumbar spine. The request is for AMITRIPTYLINE 4%, BACLOFEN 4%, GABAPENTIN 5%, CYCLOBENZAPRINE 2%, FLURBIPROFEN 10%, CLONDINE 0.2%, BUPIVICAINE 2%, 180 GRAMS. The RFA is dated 04/20/15 and the patient's work status is not provided. MTUS guidelines have the following regarding topical creams (p111, chronic pain section): "Topical analgesics are largely experimental and used with few randomized controlled trials to determine efficacy or safety. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Non-steroidal anti-inflammatory agents (NSAIDs): The efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Gabapentin: Not recommended. Flurbiprofen, an NSAID, is indicated for peripheral joint arthritis/tendinitis. Cyclobenzaprine is a muscle relaxant and is not supported for any topical formulation. MTUS continues to state that many agents are compounded for pain control including antidepressants and that there is little to no research to support their use. ?There is currently one Phase III study of baclofen-amitriptyline-ketamine gel

in cancer patients for treatment of chemotherapy-induced peripheral neuropathy. There is no peer review literature to support the use of topical baclofen. The patient is diagnosed with lumbar disc disease, lumbar Radiculopathy, and lumbar facet syndrome. She has an antalgic gait on the left, has diffuse lumbar paraspinous muscle tenderness, moderate lumbar facet pain over L5-S1 facets, and decreased sensation in the L5 dermatome on the right and L5/S1 dermatome on the left. Amitriptyline is a tricyclic anti-depressant. MTUS specifically states that Amitriptyline and Baclofen are not recommended and this ingredient has not been tested for transdermal use with any efficacy. The requested compounded cream also contains Gabapentin which is not indicated by guidelines. MTUS Guidelines page 111 do not recommend a compounded product if one of the compounds are not indicated for use. Neither Amitriptyline, Baclofen, Gabapentin, nor Cyclobenzaprine are indicated for topical cream. Therefore, the requested compounded medication IS NOT medically necessary.

Interferential Unit 30 days Trial for Home Use: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

Decision rationale: The patient was injured on 02/09/15 and presents with pain in the lumbar spine. The request is for INTERFERENTIAL UNIT 30 DAYS TRIAL FOR HOME USE. The utilization review denial rationale is that evidence based guidelines do not support interferential stimulation in the management of the cited injuries. The RFA is dated 04/20/15 and the patient's work status is not provided. For Interferential Current Stimulation (ICS), MTUS guidelines, pages 118 - 120, state that not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. These devices are recommended in cases where (1) Pain is ineffectively controlled due to diminished effectiveness of medications; or (2) Pain is ineffectively controlled with medications due to side effects; or (3) History of substance abuse; or (4) Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or (5) Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). The patient is diagnosed with lumbar disc disease, lumbar Radiculopathy, and lumbar facet syndrome. She has an antalgic gait on the left, has diffuse lumbar paraspinous muscle tenderness, moderate lumbar facet pain over L5-S1 facets, and decreased sensation in the L5 dermatome on the right and L5/S1 dermatome on the left. The 04/02/15 report states that the patient has failed conservative treatment including physical therapy, chiropractic treatment, medication, rest, and home exercise program of more than six weeks over the past 12 months. Given the patient's symptoms, a trial of an interferential unit is appropriate to determine its effects and benefits of use. The request IS medically necessary.

Bilateral L5-S1 and Left S1 Transforaminal Epidural Steroid Injection x 2: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections Page(s): 46-47.

Decision rationale: The patient was injured on 02/09/15 and presents with pain in the lumbar spine. The request is for BILATERAL L5-S1 AND LEFT S1 TRANSFORAMINAL EPIDURAL STEROID INJECTION X 2 to reduce pain and inflammation, restoring range of motion and thereby facilitating progress and more active treatment programs, and avoiding surgery. The RFA dated 04/20/15 provided. Patient's work status is not available. In regards to epidural steroid injections, MTUS page 46-47 has the following criteria under its chronic pain section: "Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electro diagnostic testing... In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year." The patient is diagnosed with lumbar disc disease, lumbar Radiculopathy, and lumbar facet syndrome. She has an antalgic gait on the left, has diffuse lumbar paraspinal muscle tenderness, moderate lumbar facet pain over L5-S1 facets, and decreased sensation in the L5 dermatome on the right and L5/S1 dermatome on the left. The 03/17/15 MRI of the lumbar spine revealed that at L5-S1, there is a 4 mm midline left paracentral disc protrusion resulting in abutment of the descending left S1 nerve root. There is mild degree of central canal narrowing at this level. There is a 3 mm biforaminal disc protrusion resulting in abutment of the exiting right and left L5 nerve roots. The 04/02/15 report states that the patient has radicular symptoms on physical examination and neuroforaminal stenosis and nerve root compression on MRI. The patient has failed conservative treatment including physical therapy, chiropractic treatment, medication, rest, and home exercise program of more than six weeks over the past 12 months. In this case, treater has supported patient's low back pain and leg symptoms with physical examination, and corroborated findings with MRI. There is no indication the patient had prior ESI. This request appears reasonable and in accordance with guidelines. Therefore, the request IS medically necessary.