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| <b>Case Number:</b>   | CM15-0126697 |                              |            |
| <b>Date Assigned:</b> | 07/16/2015   | <b>Date of Injury:</b>       | 02/04/2008 |
| <b>Decision Date:</b> | 10/14/2015   | <b>UR Denial Date:</b>       | 06/02/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 06/30/2015 |

### 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 54 year old female who sustained an industrial injury on 2/4/08. Progress note dated 5/19/15 reports continued complaints of neck, back, lower extremity and bilateral knee pain. The neck pain is constant, sharp, throbbing, moderate and radiates down both upper extremities. She has numbness and tingling in the bilateral upper extremities to the fingers along with weakness. The lower back pain is constant, sharp, moderate to severe and radiates to bilateral lower extremities. She has weakness, numbness and tingling. Lower extremity pain in bilateral knees. The pain is rated 7-8/10 with medications and 10/10 without medications. Diagnoses include: chronic pain, cervical radiculitis, cervical radiculopathy, lumbar radiculopathy, osteoarthritis of the right knee, hypertension, chronic pain, status post left total knee arthroplasty. Plan of care includes: aqua therapy, home exercises, weight loss program and continue current medications. Work status: currently not working. Follow up in 1 month.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Aqua therapy - twice weekly for 4 weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Aquatic therapy.

**Decision rationale:** Recommended as an optional form of exercise therapy, where available, as an alternative to land-based physical therapy. Aquatic therapy (including swimming) can minimize the effects of gravity, so it is specifically recommended where reduced weight bearing is desirable, for example extreme obesity. The medical records contain no rationale to justify aquatic therapy. There was no documentation that the injured worker is unable to participate in land based physical therapy. The request is not medically necessary.

**Cosamin DS 500 - 400 mg #90:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Glucosamine (and Chondroitin Sulfate).

**Decision rationale:** Per MTUS CPMTG with regard to glucosamine and chondroitin sulfate: "Recommended as an option given its low risk, in patients with moderate arthritis pain, especially for knee osteoarthritis." Per the medical records, the injured worker has osteoarthritis of the right knee, and is status post left total knee arthroplasty 2012. I respectfully disagree with the UR physician's denial based upon lack of documented functional benefit with the use of this medication. The guidelines do not mandate this documentation for its use. That the reason MTUS does not require documentation of efficacy may be that is that it may have a preventative or disease modifying effect. The request is medically necessary.

**Lidocaine 2% jell #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**Decision rationale:** The MTUS Chronic Pain Medical Treatment Guidelines p112 states "Lidocaine Indication: Neuropathic pain 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). Topical lidocaine, in the formulation of a dermal patch (Lidoderm) has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. Per the cited guidelines above, topical lidocaine is only recommended in the formulation of a dermal patch. As such, the request is not medically necessary.

**Lidoderm 5% patch #30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**Decision rationale:** The MTUS Chronic Pain Medical Treatment Guidelines p112 states "Lidocaine Indication: Neuropathic pain. 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). Topical lidocaine, in the formulation of a dermal patch (Lidoderm) has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. The medical records submitted for review do not indicate that there has been a trial of first-line therapy (tri-cyclic or SNRI antidepressants or an AED). There is also no diagnosis of diabetic neuropathy or post-herpetic neuralgia. As such, Lidoderm is not recommended at this time. The request is not medically necessary.

**Tizanidine 4 mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

**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." Per MTUS CPMTG p66 "Tizanidine is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity; unlabeled use for low back pain. (Malanga, 2008) Eight studies have demonstrated efficacy for low back pain. (Chou, 2007) One study (conducted only in females) demonstrated a significant decrease in pain associated with chronic myofascial pain syndrome and the authors recommended its use as a first line option to treat myofascial pain." UDS that evaluate for Tizanidine can provide additional data on whether the injured worker is compliant, however in this case there is no UDS testing for Tizanidine. The documentation submitted for review indicates that the injured worker has been using this medication since at least 4/2015. As the guidelines recommended muscle relaxants for short-term use only, the request is not medically necessary and cannot be affirmed.

**Ferrous sulfate 325 mg #30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation [www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010785/](http://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0010785/).

**Decision rationale:** The MTUS CPMTG and ODG guidelines are silent on the use of ferrous sulfate. Per the US National Library of Medicine: Iron is a mineral that the body needs to produce red blood cells. When the body does not get enough iron, it cannot produce the number of normal red blood cells needed to keep you in good health. This condition is called iron deficiency (iron shortage) or iron deficiency anemia. The medical records submitted for review do not contain evidence of an iron deficiency for which ferrous sulfate would be indicated. The request is not medically necessary.

**MRI - cervical spine:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004.

**MAXIMUS guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies.

**Decision rationale:** ACOEM guidelines support ordering of imaging studies for emergence of red flags, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery, and clarification of the anatomy prior to an invasive procedure. Physiologic evidence may be in the form of definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. Per the medical records, the injured worker's previous cervical MRI was 7 years ago. I respectfully disagree with the UR physician. The injured worker has had considerable persistent pain with negative impact on function, and has failed more conservative treatment. The neck pain is constant, sharp, throbbing, moderate and radiates down both upper extremities. She has numbness and tingling in the bilateral upper extremities to the fingers along with weakness. The request is medically necessary.

**ThermoCool compression system:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, Continuous-flow cryotherapy.

**Decision rationale:** The MTUS is silent on the use of cold therapy units. The ODG states continuous-flow cryotherapy is "Recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect on more frequently treated acute injuries (e.g., muscle strains and contusions) has not been fully evaluated. The available scientific literature is insufficient to document that the use of continuous-flow cooling systems (versus ice packs) is associated with a benefit beyond convenience and patient compliance (but

these may be worthwhile benefits) in the outpatient setting." The injured worker is not post-surgical. There is no indication for the requested thermocool system. The request is not medically necessary.