MAXIMUS Federal Services

Case Number:	CM13-0044786		
Date Assigned:	12/27/2013	Date of Injury:	11/20/2006
Decision Date:	02/26/2014	UR Denial Date:	10/18/2013
Priority:	Standard	Application Received:	11/01/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Texas and Oklahoma. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 59-year-old female who reported an injury on 11/20/2006. The mechanism of injury was not submitted. The patient was diagnosed with status post left total knee replacement in 04/2012; right knee internal derangement; disc herniation at L4-5 measuring 6 mm with moderate right neural foraminal stenosis; grade 1 anterolisthesis at L5-S1 with moderate right greater than left neural foraminal stenosis; severe facet arthropathy at L4-5 and L5-S1 bilaterally; right greater than left lower extremity lumbar radiculopathy; disc herniation at L3-4 and L4-5 measuring 2 mm; right tarsal tunnel syndrome; gastroesophageal reflux disease; obesity; and left ankle sprain/strain with tendonitis. The patient continued to complain of intermittent low back pain, rated 4/10 to 6/10 with radiation to the right lower extremity, associated with numbness and tingling. The patient had an injection that provided 50% improvement of pain with the injection. However, the radiation through the right lower extremity feels the same since the last visit. The patient reported limited quality of life secondary to pain. The physical examination revealed range of motion flexion with lumbar spine at 45 degrees, extension at 20 degrees, right lateral bend 10 degrees, and left lateral bend 10 degrees. The patient had a positive straight leg raise on the right and negative to the left. Lower motor strength testing revealed weakness in the right tibialis anterior and extensor hallucis longus muscle groups at 4/5. The right gastrocnemius was 0/5. The patient's medications included Percocet 10/325 mg and Flexeril 10 mg which provide 80% symptomatic relief. The patient had a transforaminal epidural injection on 08/27/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

Aquatic Therapy, 12 sessions 2 times a week for 6 weeks to Lumbar Spine and Bilateral Knees: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98-99.

Decision rationale: Chronic Pain Medical Treatment Guidelines states active therapy requires an internal effort by the individual to complete a specific exercise or task. Patients are instructed and expected to continue active therapies at home as an extension to the treatment process in order to maintain improvement levels. The guidelines also recommend aquatic therapy as an optional form of exercise therapy. The patient complained of low back pain status post an epidural steroid injection and aquatic therapy. However, no objective clinical documentation was submitted indicating continued functional deficits as the patient had previously participated in aquatic therapy. Given the lack of documentation to support guideline criteria, the request is non-certified.

Percocet 10/325mg, tablet P.O. Q6H P.R.N #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section On-going opioid management Page(s): 78.

Decision rationale: Chronic Pain Medical Treatment Guidelines recommends 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 the last assessment; average pain; intensity of pain after taking the opiate; how long it takes for pain relief; and how long pain relief last. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The patient continued to complain of low back pain. However, the clinical documentation submitted for review indicated that the patient's functioning level had not increased nor had the patient experienced any improvement in the quality of life. Also, clinical documentation did not address side effects or discuss the patient's pain assessment. Given the lack of documentation to support guideline criteria, the request is non-certified.

Flexeril 10mg #90, T.I.D #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63-64.

Decision rationale: Chronic Pain Medical Treatment Guidelines recommends nonsedating muscle relaxants with caution as a second line option for short-term treatment of acute exacerbations in patients with chronic low back pain. The guidelines also state Flexeril is recommended for short-term course of therapy. Limited, mixed evidence does not allow for a recommendation for chronic use. The patient had continued pain to the low back. However, the clinical documentation did not indicate the patient having muscle spasms symptoms. Also, there is no indication as to how long the patient has been taking Flexeril. Given the lack of documentation to support guideline criteria, the request is non-certified.

Prilosec 20mg 1 tablet P.O. Q.D #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (Non-Steroidal Anti-Inflammatory Drugs) Page(s): 67-68.

Decision rationale: Chronic Pain Medical Treatment Guidelines states patients at intermediate risk for gastrointestinal events and no cardiovascular disease should use a nonselective NSAID with either a proton pump inhibitor, for example, 20 mg Omeprazole daily or a COX 2 selective agent. The patient complained of intermittent low back pain at a 4/10 to 6/10. However, the clinical documentation submitted for review does not indicate any gastrointestinal issues. Given the lack of documentation to support the guideline criteria, the request is non-certified.