

<b>Case Number:</b>	CM13-0048098		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	04/25/2010
<b>Decision Date:</b>	02/26/2014	<b>UR Denial Date:</b>	10/24/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/04/2013

### 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, has a subspecialty in Interventional Spine, and is licensed to practice in California. 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 56-year-old female with date of injury of 4/25/10. The progress report dated 10/1/13 by [REDACTED] indicates that the patient's diagnoses include: (1) Lumbar spine pain, moderate degenerative changes at L5-S1, mild degenerative changes at L4-L5 on x-ray dated 4/4/13, a 1-cm lipoma versus hemangioma at L2 vertebral body, L3-L4 a 1-2 mm disk bulge effacing the ventral thecal sac with mild right neuroforaminal narrowing, L4-L5 a 2-3 mm disk bulge and annular tear effacing the ventral thecal sac with severe right and mild to moderate left neuroforaminal narrowing, L5-S1 a 1-2 mm disk bulge effacing the ventral thecal sac; (2) Pelvic pain, mild degenerative changes of the right hip weight bearing area on an x-ray dated 4/4/13; (3) Bilateral knee pain and internal derangement, mild narrowing of the medial knee joint. Right knee lateral patellar tilt on an x-ray dated 4/4/13. Prepatellar soft-tissue edema consistent with intrasubstance degeneration of the posterior horn of the medial meniscus, tears not excluded, and small joint effusion on the left knee MRI dated 9/4/13. The patient continues with significant pain in the lumbar spine and bilateral knees, rated 6-9/10. The patient reports swelling of the right more than the left knee. There is occasional giving way of the right knee, but she has not fallen. Objective findings state the patient weighs 303 pounds, with a blood pressure of 159/72 mmHg, and a pulse of 87 bpm. Medications for the patient included 60 Tramadol 50mg as needed for pain, and a topical cream containing Motrin. A request was made for functional capacity evaluation for the primary treating physician's permanent and stationary report. This was needed to determine if an employee is able to resume working in a capacity commensurate with his or her skills or abilities. Computerized range of motion and muscle testing was also requested for the spine.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Naprosyn topical cream:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

**Decision rationale:** The patient continues with significant low back pain and bilateral knee pain, with mild narrowing of the medial knee joint on x-ray. The treating physician's report from 12/17/13 also indicates that the patient is using topical cream, and under treatment discussion, he prescribed "topical cream, Naprosyn." The MTUS Guidelines regarding topical analgesics for nonsteroidal anti-inflammatory agents, state that they may be used for osteoarthritis and tendonitis, in particular that of the knee and elbow or other joints that are amenable to topical treatment. This patient suffers from chronic bilateral knee pains, and recommendation is for authorization. The request is certified.

**Tramadol 50mg:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 80.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78-81.

**Decision rationale:** The records indicate the patient was started on Tramadol 50mg going as far as back as 8/1/13. She has moderate to severe pain rated 6-9/10 which has been consistent with the reports from 8/1/13 through 12/17/13. The treating physician does not indicate that the patient has experienced temporary relief of pain whether or not the patient has had any negative side effects or any significant functional improvement in activities of daily living due to medication use. The MTUS suggests 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 last. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The 4 A's for ongoing monitoring including analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors should be assessed. The records indicate that the patient's pain was assessed on majority of the visits. However, no functional improvement was documented other than stating the patient had temporary relief. The treating physician has not documented adequate functional benefit from this medication. The MTUS states that Tramadol is indicated for moderate to severe pain, and that it is a synthetic opioid affecting the central nervous system. The patient does seem to have moderate to severe pain; however, it is unclear if the medicine is effective in reducing the

patient's pain, improving activities of daily living, or improving quality of life. Therefore, recommendation is for denial. The request is non-certified.

**Motrin:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 22.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 60-61.

**Decision rationale:** The MTUS recommends the use of NSAIDs such as Motrin for osteoarthritis of the knees. The patient continues with significant knee pain, and has been prescribed Motrin as needed to manage that pain. The recommendation is for authorization. The request is certified.

**The request for a functional capacity evaluation:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation the Independent Medical Examinations and Consultations (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 7), page 138.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation the Independent Medical Examinations and Consultations (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 7), pages 137, 138.

**Decision rationale:** The treating physician indicates that the functional capacity evaluation is needed to determine if the employee is able to resume working in a capacity commensurate with his or her skills or abilities. The ACOEM Guidelines state that the examiner is responsible for determining the impairment results and functional limitations, and to inform the examinee and the employer about the examinee's abilities and limitations. These assessments may be ordered by the treating or evaluating physician if the physician feels the information from such testing is crucial. The ACOEM further states that there is little scientific evidence confirming that functional capacity evaluations predict an individual's actual capacity to perform in the workplace. The Guidelines do not appear to provide support for the requested functional capacity evaluation. Therefore, recommendation is for denial. The request is non-certified.

**The request for range of motion muscle testing:** Upheld

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

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

**Decision rationale:** The treating physician does not provide the rationale why computerized range of motion for muscle testing is indicated. The MTUS is silent on range of motion testing; therefore, the Official Disability Guidelines were reviewed. The ODG states that range of motion testing is not recommended as a primary procedure, but should be part of the routine musculoskeletal evaluation. The ODG further references AMA Guidelines to the evaluation of a permanent impairment, which states that an inclinometer is the preferred device for obtaining accurate, reproducible measurements in a simple, practical, and inexpensive way. They do not recommend the computerized measures of lumbar spine range of motion because it can be done with inclinometers, and the results are of unclear therapeutic value. The above guidelines do not appear to support the use of the requested computerized spinal range of motion. Therefore, recommendation is for denial. The request is non-certified.