

<b>Case Number:</b>	CM13-0051502		
<b>Date Assigned:</b>	02/20/2014	<b>Date of Injury:</b>	01/30/2005
<b>Decision Date:</b>	06/13/2014	<b>UR Denial Date:</b>	10/16/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/14/2013

### 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. The expert reviewer is Board Certified in Occupational Medicine 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 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/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:

This is a 30 year old female reported low back and shoulder pain, and mental illness, after an injury on 01/30/05. Orthopedic diagnoses have included lumbar disc disease and radiculopathy. Treatment has included two lumbar surgeries (fusion and hardware removal), polypharmacy visits for care with multiple physicians, prolonged disability, injections, psychotherapy, and acupuncture. The treating surgeon removed the hardware in October 2012. After the surgery, the injured worker had at least two inpatient physical therapy sessions. Outpatient physical therapy, 18 visits, was recommended on 3/5/13 and 4/16/13. 12 visits of physical therapy were recommended on 7/16/13. A Medrol Dosepak was prescribed in the acute post-operative period, on 3/5/13, and 4/16/13. Lumbar epidural steroid injections were prescribed on 3/5/13, and 4/16/13. The surgeon prescribed morphine and oxycodone in the post-operative period, and continued to prescribe oxycodone chronically, although no treating surgeon reports discuss the prescribing of this medication. Several urine drug screens showed oxycodone. The medical reports are brief and do not discuss the ongoing medication regime. On 8/10/13 the injured worker visited the hospital Emergency Department for low back pain, stating that she was out of her medications. She was given Percocet #18. On 9/17/13 the treating surgeon noted ongoing 10/10 pain since the last surgery, numbness in the right leg, and a recent fall. Radicular findings were present, without signs of significant neurological loss. The treatment plan included an MRI, aquatic therapy, Medrol Dosepak, Endocet refill, benzodiazepines, and other medications. Work status remained as temporary total disability. There was no mention of the prior oxycodone prescriptions, the specific results of using opioids, or the last Emergency Department visit.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TWELVE AQUATIC PHYSICAL THERAPY SESSIONS FOR THE LUMBAR SPINE:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 98.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic Therapy; Physical Medicine Page(s): 22, 98-99.

**Decision rationale:** This injured worker is past the post-operative period of 6 months, as defined in the MTUS for post-operative physical medicine. The medical necessity for additional physical therapy, if any, is based on the MTUS recommendations for Physical Medicine and Aquatic Therapy listed above. Although the treating physician has listed physical therapy in several progress reports, there are no actual prescriptions or any discussion of physical therapy results in the medical records. It is not clear if the injured worker completed any physical therapy other than a few inpatient sessions after the surgery. There are no essential exercises or therapy for the back which can only be performed in the water. Medical necessity, if any, is based on the requirement that this or any other patient must exercise only in the water. The MTUS for Chronic Pain notes that aquatic therapy is recommended where reduced weight bearing is desirable, as with extreme obesity. In general, patients should perform land therapy, in that land exercise is essential for development of strength, proprioception, and core stabilization. The MTUS for aquatic therapy recommends, for those patients who need this kind of therapy, that the number of supervised visits are those outlined in the Physical Medicine section. The Physical Medicine section lists 8-10 visits for the usual sorts of chronic pain. The prescription is for 12, which exceeds the quantity recommended in the MTUS. There is no specific prescription, no functional goals, and no specific exercises. The prescription is not accompanied by any physician reports which adequately address function, as the PR-2 refers only to inability to perform any and all work, which is not an accurate or appropriate work status this long after surgery when the emphasis should be on functional restoration. This injured worker does not have extreme obesity or any other apparent indication for aquatic therapy. The referral for aquatic therapy is not medically necessary based on the lack of indications as specified in the MTUS, the lack of a specific treatment plan for functional restoration, and the excessive quantity of visits.

**ENDOCET 10/325MG, #180:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 77-81, 80, 94.

**Decision rationale:** There is no evidence that the treating physician is prescribing opioids according to the MTUS, which recommends prescribing according to function, with specific functional goals, return to work, random drug testing, opioid contract, and there should be a prior

failure of non-opioid therapy. None of these aspects of prescribing are in evidence. Emergency Department visits for opioids are a red flag indicator for possible misuse of opioids. The treating physician did not address this. Drug tests are performed at the time of office visits, which is not random. Per the MTUS, opioids are minimally indicated, if at all, for chronic back pain. Aberrant use of opioids is common in this population. There is no evidence of significant pain relief or increased function from the opioids used to date. Pain levels have been 8-10/10 over the last few months even while on opioids, and this has not been discussed by the treating physician. The prescribing physician describes this patient as "temporary total disability", which generally represents a failure of treatment, as this implies confinement to bed for most or all of the day. None of the treating physician reports address the ongoing use of opioids in light of the MTUS recommendations and the poor function and pain relief. Continued opioids are not medically necessary based on the poor function, poor pain relief, and the lack of a treatment plan that is in accordance with the MTUS.

**MEDROL DOSEPAK:** 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), LOW BACK- LUMBAR & THORACIC (ACUTE & CHRONIC).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 120, 121.

**Decision rationale:** This injured worker has chronic back with radicular symptoms. The MTUS recommends against oral steroids for back pain. The updated ACOEM Guidelines recommends oral steroids only for acute radicular pain. Pain in this case is not acute, as it has been present for years. The treating physician has already given this injured worker three courses of Medrol orally after the surgery in 2012. There was no benefit from that treatment. Additional courses of oral steroids are not medically necessary based on guideline recommendations, the cumulative risks of additional steroids, and the lack of benefit from the prior courses of steroids.