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| <b>Case Number:</b>   | CM14-0065433 |                              |            |
| <b>Date Assigned:</b> | 07/11/2014   | <b>Date of Injury:</b>       | 02/19/2014 |
| <b>Decision Date:</b> | 12/31/2014   | <b>UR Denial Date:</b>       | 05/02/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 05/08/2014 |

### 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 Internal 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:

The patient is an injured worker with the diagnoses of lumbosacral strain. Date of injury was 02-19-2014. The doctor's first report of occupational injury dated 3/18/14 documented that on February 19, 2014, he was throwing paperwork into a large dumpster when suddenly the lid slipped. To avoid being struck he turned away quickly at which time he felt pain in his lower back and neck. Subjective complaints included pain in right lower back with radiation to right buttock and right thigh and weakness in low back and legs. Objective findings were documented. Examination of the lumbar spine demonstrated slight posterior lumbar tenderness. Flexion to 60 degrees and extension to 10 degrees were noted. Sensory and motor exams were intact. Diagnosis was lumbosacral strain. The treatment plan included orthopedic consultation and referral for physical therapy. Lumbar spine plain film dated 2/24/14 noted that five non-rib bearing lumbar vertebral bodies are present. The pedicles are intact. The pars are also intact. Lumbar vertebral bodies show no displacement. Vertebral body height is maintained. Disc spaces are maintained. Significant posterior facet arthropathy is not seen. Atherosclerotic calcification of the abdominal aorta is noted. No acute bony abnormality. Significant degenerative disease by plain film is not identified. The physical therapy progress report dated March 12, 2014 noted that the patient reports he has more pain in this neck now and low back pain now radiates down right leg to just behind the knee. Patient returned for the first treatment after the initial evaluation on 03/04/2014. Patient reports lumbar spine pain now goes across entire low back and not just on right side. Patient also reports his low back pain goes down right buttocks down to behind the knee. Patient also reports neck pain is increasing. Patient remains off work at this time. Five physical therapy treatments were approved. The physical therapy progress report dated 3/13/14 documented a second physical therapy treatment visit. The patient's medications included Naproxen, Robaxin, Vicodin, Metformin, and Benazepril. The

progress report dated 04/08/14 documented subjective complaints of low back pain and stiffness. Physical examination demonstrated tenderness to palpation in the lower lumbar paravertebral musculature. Forward flexion was 45 degrees. Extension is 10 degrees. Lateral bending is 20 degrees. Strength in the lower extremities is globally intact. Straight leg raise was negative bilaterally. Diagnosis was lumbosacral strain. The treatment plan included requests for physical therapy, Voltaren, Ultram, and Ambien.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **PT 3X4 LUMBAR: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy (PT) Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic) Physical therapy (PT)

**Decision rationale:** Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines provide physical therapy (PT) physical medicine guidelines. For myalgia and myositis, 9-10 visits are recommended. For neuralgia, neuritis, and radiculitis, 8-10 visits are recommended. Official Disability Guidelines (ODG) recommends 10 visits for lumbar sprains and strains. The physical therapy progress report dated March 12, 2014 documented that the initial physical therapy evaluation was performed on 03/04/2014. The physical therapy progress report dated 3/12/14 documented that 5 physical therapy treatments were approved. The physical therapy progress report dated 3/13/14 documented the performance of a physical therapy treatment visit. MTUS and ODG guidelines allow for up to 10 physical therapy visits. Per ODG guidelines, when the number of visits exceeds the guidelines, exceptional factors should be noted. The patient had previously been approved for 5 physical therapy visits. Functional improvements were not documented with the fifth physical therapy treatment in the submitted medical records. The request dated 4/26/14 for 12 additional physical therapy visits would exceed MTUS guideline recommendations. No exceptional factors were noted supporting the request to exceed MTUS guideline recommendations. Therefore, the request for 12 additional physical therapy visits is not supported by MTUS and ODG guidelines. Therefore, the request for Physical Therapy 3x4 Lumbar is not medically necessary.

#### **VOLTAREN 75MG, #60 RF: 2: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-73.

**Decision rationale:** Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines addresses NSAIDs (non-steroidal anti-inflammatory drugs). All NSAIDs have the U.S. Boxed Warning for associated risk of adverse cardiovascular events, including, myocardial infarction, stroke, and new onset or worsening of pre-existing hypertension. NSAIDs can cause ulcers and bleeding in the stomach and intestines at any time during treatment. Use of NSAIDs may compromise renal function. FDA package inserts for NSAIDs recommend periodic lab monitoring of a CBC and chemistry profile including liver and renal function tests. Routine blood pressure monitoring is recommended. It is generally recommended that the lowest effective dose be used for all NSAIDs for the shortest duration of time. All NSAIDs have the potential to raise blood pressure in susceptible patients. The greatest risk appears to occur in patients taking the following anti-hypertensive therapy: angiotensin-converting enzyme (ACE) inhibitors, angiotensin receptor blockers, beta-blockers, or diuretics. Medical records indicate the long-term use of NSAIDs. Per MTUS, it is generally recommended that the lowest dose be used for NSAIDs for the shortest duration of time. Medical records do not present recent laboratory test results, which are recommended for NSAID use per MTUS. No recent blood pressure measurements were present in the medical records. MTUS guidelines recommend monitoring of blood pressure. The long-term NSAID use is not recommended by MTUS. Medical records indicate a diagnosis of Hypertension managed with Benazepril. Per MTUS, NSAIDs are associated with the risk of adverse cardiovascular events, including, myocardial infarction, stroke, and new onset or worsening of pre-existing hypertension. MTUS guidelines warn against the use of NSAIDs with patients with hypertension. The use of the NSAID Voltaren is not supported by medical records and MTUS guidelines. Therefore, the request for Voltaren 75mg, #60 Refill: 2 is not medically necessary.

**ULTRAM 50MG, #60 RF: 2:** Overtuned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram) Page(s): 93-94, 113, 123.

**Decision rationale:** Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines address Ultram (Tramadol). Ultram is a centrally acting synthetic opioid analgesic. Ultram is indicated for the management of moderate to moderately severe pain. Medical records document a diagnosis of lumbosacral strain with a date of injury of 2/19/14. Physical examination demonstrated lumbosacral tenderness and decreased range of motion. The patient reported low back pain. Per MTUS, Ultram (Tramadol) is indicated for the management of moderate to moderately severe pain. MTUS guidelines support the prescription of Ultram (Tramadol). Therefore, the request for Ultram 50mg, #60 Refill: 2 is medically necessary.

**AMBIEN 10MG, #30 & RF: 2:** 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 Official Disability Guidelines (ODG) Pain (Chronic) Zolpidem (Ambien)

**Decision rationale:** Medical Treatment Utilization Schedule (MTUS) does not address Zolpidem (Ambien). Official Disability Guidelines (ODG) state that Zolpidem is approved for the short-term, usually two to six weeks, treatment of insomnia, and should be used for only a short period of time. The progress report dated 04/08/14 documented a request for Ambien. No sleep symptoms were documented. There was no documentation of insomnia diagnosis. Ambien 10 mg qhs prn #30 with 2 refills were requested, which is equivalent to a 90 day supply. ODG guidelines states that Zolpidem should be used for only a short period of time. The long-term use of Ambien (Zolpidem) is not supported by ODG guidelines. Therefore, the request for Ambien 10mg, #30, Refill: 2 is not medically necessary.