

<b>Case Number:</b>	CM14-0082483		
<b>Date Assigned:</b>	07/21/2014	<b>Date of Injury:</b>	04/23/2007
<b>Decision Date:</b>	09/19/2014	<b>UR Denial Date:</b>	05/02/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/04/2014

### 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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Management 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 patient with a date of injury of 4/23/07. A utilization review determination dated 5/2/14 recommends non-certification of aquatic physical therapy, Flexeril, and random urine tox screen. It referenced a 4/9/14 medical report identifying pain in the neck, back, and knee. Pain is 4/10 with medications and 8/10 without. The patient reports that medications allow him to function with ADLs and he would be bedridden without them. On exam, there is paralumbar spasm, reduced AROM, SLR positive bilaterally at 70 degrees due to low back, posterior thigh, and calf pain, more on the left. There is slight tenderness and spasm in the parathoracic and paracervical muscles with reduced AROM and positive Spurling sign. Gait is slow and antalgic with use of a single point cane. A signed opioid contract is said to be present and urine toxicology screen was requested to monitor compliance. UDS report from 4/9/14 was positive for pregabalin and carboxy-THC. 4/3/14 PT report notes that 6 sessions of therapy have been completed. The patient feels like he can do more in the pool versus outside of the pool because there is no increase in pain while in the water. Short-term goals have been met and he is demonstrating very slow progress towards the long-term goals. Previous UDS was noted to have been certified on 2/25/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Aquatic physical therapy, six (6) additional visits.:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 22, 98-99 of 127.

**Decision rationale:** Regarding the request for aquatic physical therapy, Chronic Pain Treatment Guidelines state that up to 10 sessions of aquatic therapy are recommended as an optional form of exercise therapy where available as an alternative to land-based physical therapy. They go on to state that it is specifically recommended whenever reduced weight bearing is desirable, for example extreme obesity. Within the documentation available for review, there is no documentation of failure of a land-based independent home exercise program and a rationale identifying why the patient would require therapy in a reduced weight-bearing environment rather than land-based treatment, although the therapist notes that the patient feels like he can do more in the pool versus outside of the pool because there is no increase in pain while in the water. Furthermore, the patient has completed 6 sessions to date. The current request for 6 additional sessions exceeds the recommendations of the CA MTUS and, unfortunately, there is no provision for modification of the current request. In light of the above issues, the currently requested aquatic physical therapy is not medically necessary.

**Flexeril 10mg every evening, #30.:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain); Cyclobenzaprine (Flexeril, Amrix, Fexmid, generic available).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 63-66 of 127.

**Decision rationale:** Regarding the request for Flexeril, Chronic Pain Medical Treatment Guidelines support the use of nonsedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Within the documentation available for review, there is no identification of significant improvement as a result of the Flexeril, as the patient continues to have muscle spasms. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. In the absence of such documentation, the currently requested Flexeril is not medically necessary.

**Random urine toxicology screen.:** 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), Urine drug testing (UDT).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 76-79 and 99 of 127.

**Decision rationale:** Regarding the request for a random urine toxicology screen, CA MTUS Chronic Pain Medical Treatment Guidelines state the drug testing is recommended as an option. Guidelines go on to recommend monitoring for the occurrence of any potentially aberrant (or nonadherent) drug related behaviors. ODG recommends urine drug testing on a yearly basis for low risk patients, 2-3 times a year for moderate risk patients, and possibly once per month for high risk patients. Within the documentation available for review, there is no documentation of current risk stratification to identify the medical necessity of drug screening at the proposed frequency, as the patient was authorized for prior screening less than two months before the current request. In light of the above issues, the currently requested random urine toxicology screen is not medically necessary.