

<b>Case Number:</b>	CM14-0097034		
<b>Date Assigned:</b>	07/28/2014	<b>Date of Injury:</b>	08/09/2000
<b>Decision Date:</b>	09/09/2014	<b>UR Denial Date:</b>	06/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/25/2014

### 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 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 injured worker is a 65-year-old female with a reported date of injury on 10/09/2000. The mechanism of injury was not submitted within the medical records. Her diagnoses were noted to include lumbago and low back pain. Her previous treatments were noted to include medications, light stretching, and exercise. The progress note dated 05/06/2014, revealed the injured worker complained of low back pain, along with mid back pain rated 6/10 with medications and 8/10 without medications. The injured worker indicated she was able to perform house or yard work, self-care, and was able to drive with utilization of medications. The injured worker complained of back pain, myalgias, muscle weakness, stiffness, and joint pain. The injured worker also complained of depression, but denied anxiety. The physical examination revealed tenderness to the lumbar spine, facet joint and decreased range of motion. The request for authorization form was not submitted within the medical records. The request was for a lumbar spine orthosis for pain and weakness, physical therapy for thoracic pain 3 times a week for 4 weeks, Oxycodone 10 mg #180 for pain, and Lexapro 10 mg #30 x 4 refills. However, the provider's rationale was not submitted within the medical records.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lumbar Spine Orthosis:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308.

**Decision rationale:** The request for a lumbar spine orthosis is not medically necessary. The CA MTUS/ACOM Guidelines do not recommend lumbar supports for the treatment of low back disorders. The guidelines state lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. The injured worker injured her back 14 years ago and is considered to be in the chronic phase. The guidelines recommend lumbar support in the acute phase of symptom relief. Therefore, the request is not medically necessary.

**Physical Therapy for Thoracic Pain 3 x per Week x 4 Weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back Procedure Summary Last Updated 5/12/14: Evidence Citations for Physical Therapy.

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

**Decision rationale:** The request for physical therapy for thoracic pain 3 times per week times 4 weeks is not medically necessary. The injured worker complains of low back pain and decreased range of motion. The California Chronic Pain Medical Treatment Guidelines recommend active therapy based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. 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 of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. The guidelines recommend for myalgia and myositis 9-10 visits over 8 weeks. There is lack of documentation regarding previous physical therapy sessions or quantifiable objective functional improvements with previous physical therapy. There is lack of documentation regarding current measurable objective functional deficits and previous number of physical therapy sessions completed. Additionally, the request for 12 sessions of physical therapy exceeds guideline recommendations. Therefore, the request is not medically necessary.

**Lexapro 10mg #30 x 4 Refills:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines Antidepressants.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13.

**Decision rationale:** The request for Lexapro 10 mg #30 x 4 refills is not medically necessary. The injured worker has been utilizing this medication since at least 01/2014. The California Chronic Pain Medical Treatment Guidelines recommend antidepressants as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. Tricyclics are generally considered a first line agent unless they are ineffective, poorly tolerated, or contraindicated. Analgesia generally occurs within a few days to a week, whereas antidepressant effects take longer to occur. Assessment of treatment efficacy should include not only pain outcomes, but also an evaluation of function, changes in the use of other analgesic medication, sleep quality and duration, and psychological assessments. The guidelines state a systematic review indicated that tricyclic antidepressants have demonstrated a small to moderate effect on chronic low back pain, but the effect on function is unclear. The guidelines also state antidepressants are an option for radiculopathy, but there are no specific medications that have been proven in high quality studies to be efficacious for treatment of lumbosacral radiculopathy. There is a lack of documentation regarding efficacy of this medication, and the injured worker did not report radiating pain. The injured worker did complain of depression, but denied anxiety. Therefore, due to the lack of documentation regarding treatment efficacy including pain outcomes, improved function, changes in use of other analgesic medications, sleep quality and duration, and psychological assessment, the ongoing use of Lexapro is not appropriate at this time. Additionally, the request failed to provide the frequency at which this medication is to be utilized. As such, the request is not medically necessary.

**Oxycodone 10mg #180:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-going Management Page(s): 78.

**Decision rationale:** The request for Oxycodone 10 mg #180 is not medically necessary. The injured worker has been utilizing this medication since at least 01/2014. According to the California Chronic Pain Medical Treatment Guidelines, the ongoing use of opioid medications may be supported with detailed documentation of pain relief, functional status, appropriate medication use, and side effects. The guidelines also state that the 4 A's for ongoing monitoring, including analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors should be addressed. The injured worker indicated her pain scale was 6/10 with medications and 8/10 without medications. The injured worker indicated she could perform some house or yard work, self-care, and was able to drive with the utilization of this medication. There is a lack of documentation regarding side effects. The urine drug screen performed 01/2014 revealed negative results in regards to opiates. Therefore, despite the lack of documentation regarding significant pain relief, improved functional status, without details regarding side effects and inconsistent urine drug screens, the ongoing use of opioid medications is not supported by the guidelines. Additionally, the request failed to provide the frequency at which this medication is to be utilized. As such, the request is not medically necessary.