

Case Number:	CM14-0099260		
Date Assigned:	07/28/2014	Date of Injury:	03/31/2010
Decision Date:	08/29/2014	UR Denial Date:	06/06/2014
Priority:	Standard	Application Received:	06/27/2014

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 Anesthesiology, Pain Medicine, and is licensed to practice in Florida. 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 52-year-old male who reported an injury on 03/31/2010. The mechanism of injury was not noted within the review. The injured worker's diagnoses were noted to be failed back syndrome with intractable pain and lumbosacral radiculopathy; status post surgery to lumbar spine with Hemilaminectomy at L2, L4, and L5; Microdiscectomy at right L4-5; and major depression. The injured worker had prior treatments of Epidural Steroid Injections and medications. The injured worker had diagnostic testing including an EMG/NCV of the bilateral lower extremities, MRI of the thoracic spine, and a CT scan. The injured worker had a Hemilaminectomy and a Microdiscectomy. The injured worker had a clinical evaluation on 05/13/2014. The subjective complaints were noted to be constant intractable upper and lower back pain. He complained of numbness and weakness in his bilateral lower extremities. The objective findings revealed moderately restricted range of motion of the thoracic and lumbar spine in all planes. There was multiple myofascial trigger points and taut bands noted throughout the cervical paraspinal, trapezius, levator scapulae, scalene, infraspinatus, thoracic, and lumbar paraspinal musculature as well as in the gluteal muscles. The injured worker was unable to perform heel-toe gait. He was ambulating with a cane. Sensation to fine touch with pinprick was decreased in the bilateral calves. Proximal muscles of the thigh were weak at -5/5. Dorsiflexion and plantarflexion was decreased at +4/5 in both feet. Ankle jerks were absent bilaterally. The treatment plan was to refill medications, to obtain a urine drug screen, home muscle stretching exercises, and deep breathing meditation. The provider's rationale for the request was included in the documentation. A Request for Authorization for medical treatment was not provided in the documentation for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Aquatic Therapy 2 times a week for 6 weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic therapy Page(s): 22.

Decision rationale: The request for Aquatic Therapy 2 times a week for 6 weeks is not medically necessary. The California MTUS Chronic Pain Medical Treatment Guidelines recommend aquatic therapy as an optional form of exercise therapy, where available, as an alternative to land-based physical therapy. Aquatic therapy (including swimming) can minimize the effects of gravity, so it is specifically recommended where reduced weight bearing is desirable, for example extreme obesity. The guidelines allow for up to 10 visits of aquatic therapy. The provider's request for 12 visits of aquatic therapy is in excess of the guidelines. In addition, the documentation submitted for review fails to provide objective data to warrant aquatic therapy over land-based therapy. Therefore, the request for Aquatic Therapy 2 times a week for 6 weeks is not medically necessary.

Hydrocodone/APAP 10/325mg #270: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids. Decision based on Non-MTUS Citation Official Disability Guidelines-Pain Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioid On-Going Management Page(s): 78.

Decision rationale: The request for Hydrocodone/APAP 10/325mg #270 is not medically necessary. The California MTUS Chronic Pain Medical Treatment Guidelines provide 4 domains that are relevant for ongoing monitoring of chronic pain patients on opiates. These include pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant (or nonadherent) drug related behaviors. These domains have been summarized as the 4 A's (analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors). The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. The documentation submitted for review fails to provide an adequate pain assessment. The clinical documentation should include pain relief, functional status, appropriate medication use, and side effects. The pain assessment should include current pain, the least reports pain over the period since last assessment, average pain, and intensity of pain after taking the opiate, how long it takes for pain relief, and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. The documentation submitted for review provides an inadequate assessment of the injured worker's pain according to the guidelines for monitoring opiate therapy. In addition, the provider's request

fails to indicate a frequency. Therefore, the request for Hydrocodone/APAP 10/325mg #270 is not medically necessary.

Cyclobenzaprine 7.5mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ANTISPASMODICS Page(s): 64.

Decision rationale: The request for Cyclobenzaprine 7.5mg #60 is not medically necessary. The California MTUS Chronic Pain Medical Treatment Guidelines indicate Cyclobenzaprine as an Antispasmodic. This is used to decrease muscle spasm in conditions such as low back pain although it appears that these medications are often used for the treatment of musculoskeletal conditions whether spasm is present or not. Cyclobenzaprine is recommended for a short course of therapy. Limited, mixed-evidence does not allow for a recommendation for chronic use. This medication is not recommended to be used for longer than 2 to 3 weeks. According to the documentation submitted for review, it is noted that the injured worker has had Cyclobenzaprine therapy for quite some time. A document dated 06/06/2014 indicates the injured worker on Cyclobenzaprine 7.5 mg. The guidelines do not recommended Cyclobenzaprine therapy longer than 2 to 3 weeks. In addition, the provider's request fails to give a frequency. Therefore, the request for Cyclobenzaprine 7.5mg #60 is not medically necessary