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| Case Number: | CM14-0198611 | | |
| Date Assigned: | 12/08/2014 | Date of Injury: | 09/20/2008 |
| Decision Date: | 01/22/2015 | UR Denial Date: | 10/23/2014 |
| Priority: | Standard | Application Received: | 11/25/2014 |

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 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:

Injured worker is a male with date of injury 9/20/2008. Per primary treating physician's progress report dated 9/17/2014, the injured worker reports that he continues to be symptomatic. He has not had physical therapy thus far. He is usually very active, but his pain limits his activities. He has low back pain and spasms that occasionally "locks up on him". He has tingling and burning sensation down the right leg. He has right shoulder pain that limits his activities. He is unable to sleep at night due to the pain. On examination of the lumbar spine, he appears comfortable and in no acute distress. He arises from sitting to standing without difficulty. Gait is normal. Lumbar range of motion is moderately restricted with pain at the limits of his range. Motor function of the lower extremities is intact. Diagnoses include 1) lumbar strain 2) right rotator cuff tear 3) lumbar spondylosis and degenerative disc L2-L3 4) sciatica.

IMR ISSUES, DECISIONS AND RATIONALES

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

Twelve sessions of physical therapy: Upheld

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

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

Decision rationale: The MTUS Guidelines recommend physical therapy focused on active therapy to restore flexibility, strength, endurance, function, range of motion and alleviate discomfort. The MTUS Guidelines support physical therapy that is providing a documented benefit. Physical therapy should be provided at a decreasing frequency (from up to 3 visits per week to 1 or less) as the guided therapy becomes replaced by a self-directed home exercise program. The physical medicine guidelines recommend myalgia and myositis, unspecified; receive 9-10 visits over 8 weeks. The amount of physical therapy requested exceeds the recommendations of the MTUS Guidelines. The claims administrator modified to request to six sessions of physical therapy. The request for twelve sessions of physical therapy is determined to not be medically necessary.

One lumbar epidural steroid injection: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46.

Decision rationale: The MTUS Guidelines recommend the use of epidural steroid injections (ESIs) as an option for treatment of radicular pain. Radicular pain is defined as pain in dermatomal distribution with corroborative findings of radiculopathy. ESI can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. The treatment alone offers no significant long-term functional benefit. Criteria for the use of ESI include radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing, and failed conservative treatment. MRI of the lumbar spine dated 7/18/2014 indicates that the injured worker has mild disc narrowing at the L2-3 disc with a mild broad-based disc bulge with some flattening of the anterior spinal canal without significant spinal or foraminal stenosis. The physical exam does not indicate that the injured worker is experiencing radiculopathy in a dermatomal distribution that would be supported by the MRI findings. The request for one Lumbar Epidural Steroid Injection is determined to not be medically necessary.

One prescription of Norco 2.5/325mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Hydrocodone/Acetaminophen and Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids section, Weaning of Medications Page(s): 74-95 and 124.

Decision rationale: The MTUS Guidelines do not recommend the use of opioid pain medications, in general, for the management of chronic pain. There is guidance for the rare instance where opioids are needed in maintenance therapy, but the emphasis should remain on non-opioid pain medications and active therapy. Long-term use may be appropriate if the patient is showing measurable functional improvement and reduction in pain in the absence of non-

compliance. Functional improvement is defined by either significant improvement in activities of daily living or a reduction in work restriction as measured during the history and physical exam. The medical reports do not indicate that the injured worker is experiencing significant pain reduction or objective functional improvement with the use of Norco. Continued use of Norco with this injured worker is not consistent with the recommendations of the MTUS Guidelines. It is not recommended to discontinue opioid treatment abruptly, as weaning of medications is necessary to avoid withdrawal symptoms when opioids have been used chronically. This request however is not for a weaning treatment, but to continue treatment. The request for one prescription of Norco 2.5/325mg is determined to not be medically necessary.

One prescription of Tramadol 150mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids section, Weaning of Medications Page(s): 74-95 and 124.

Decision rationale: Tramadol is a central acting synthetic opioid that exhibits opioid activity with a mechanism of action that inhibits the reuptake of serotonin and norepinephrine with side effects similar to traditional opioids. The MTUS Guidelines do not recommend the use of opioid pain medications, in general, for the management of chronic pain. There is guidance for the rare instance where opioids are needed in maintenance therapy, but the emphasis should remain on non-opioid pain medications and active therapy. Long-term use may be appropriate if the patient is showing measurable functional improvement and reduction in pain in the absence of non-compliance. Functional improvement is defined by either significant improvement in activities of daily living or a reduction in work restriction as measured during the history and physical exam. The medical reports do not indicate that the injured worker is experiencing significant pain reduction or objective functional improvement with the use of Tramadol. Continued use of Tramadol with this injured worker is not consistent with the recommendations of the MTUS Guidelines. It is not recommended to discontinue opioid treatment abruptly, as weaning of medications is necessary to avoid withdrawal symptoms when opioids have been used chronically. This request however is not for a weaning treatment, but to continue treatment. Therefore, this request is not medically necessary.

One prescription of Fexmid: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine section, Muscle Relaxants (for pain) Page(s): 41, 42, 63 and 64.

Decision rationale: Cyclobenzaprine is recommended by the MTUS Guidelines for short periods with acute exacerbations, but not for chronic or extended use. These guidelines report that the effect of cyclobenzaprine is greatest in the first four days of treatment. Cyclobenzaprine

is associated with a number needed to treat of three at two weeks for symptoms improvement in low back pain and is associated with drowsiness and dizziness. Chronic use of Cyclobenzaprine may cause dependence, and sudden discontinuation may result in withdrawal symptoms. Discontinuation should include a tapering dose to decrease withdrawal symptoms. This request however is not for a tapering dose. The request for one prescription of Fexmid is determined to not be medically necessary.