

<b>Case Number:</b>	CM15-0142363		
<b>Date Assigned:</b>	08/03/2015	<b>Date of Injury:</b>	09/30/2014
<b>Decision Date:</b>	09/24/2015	<b>UR Denial Date:</b>	07/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/22/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 44-year-old male who sustained an industrial injury on September 30, 2014. He reported that a ladder slipped from under him and he fell onto his back injuring his neck, back and arm. Treatment to date has included medications and physical therapy for the left elbow. According to a handwritten, partially legible progress report dated 05/28/2015, the injured worker reported low back pain. Pain was rated 10 on a scale of 1-10. Current medications included Tylenol and Advil. Work status included modified duties. According to a progress report dated June 22, 2015, the injured worker was seen for evaluation and consultation of his low back. He had been having low back pain and pelvis pain. Current medications included Motrin. An MRI of the lumbar spine showed a 2-millimeter bulging disc, L4-5 and L5-S1. Diagnosis included discogenic back pain. Physical examination of the back demonstrated 60 degrees of flexion and 10 degrees of extension. Straight leg raise was negative for leg pain and positive for back pain. Ankle dorsi and plantar flexors were 5/5. Quadriceps were 5/5. Iliopsoas were 5/5. Fabere was negative. The treatment plan included physical therapy of the lumbar spine, Naprosyn 500 mg twice a day as needed and Prilosec 20 mg once a day as needed to minimize gastrointestinal side effects. The provider noted that the injured worker should stop using Motrin if he was on the Naprosyn. The injured worker was temporarily partially disabled with work restrictions. Currently under review is the request for Physical therapy, 2 times a week for 6 weeks, lumbar spine and Naprosyn 500 mg #60.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy, 2 times a week for 6 weeks, lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299, Chronic Pain Treatment Guidelines Physical Therapy (Effective July 18, 2009) Page(s): 98 and 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Physical Medicine.

**Decision rationale:** Regarding the request for physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course (10 sessions) of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, there is no documentation of specific objective functional improvement with any previous sessions and remaining deficits that cannot be addressed within the context of an independent home exercise program yet are expected to improve with formal supervised therapy. Furthermore, the request exceeds the amount of PT recommended by the CA MTUS and, unfortunately, there is no provision for modification of the current request. In light of the above issues, the currently requested physical therapy is not medically necessary.

**Naprosyn 500mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 47. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, (Effective July 18, 2009) Page(s): 67-72.

**Decision rationale:** Regarding the request for Naprosyn, Chronic Pain Medical Treatment Guidelines state that NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Within the documentation available for review, there is no indication that Naproxen is providing any specific analgesic benefits (in terms of percent pain reduction, or reduction in numeric rating scale), or any objective functional improvement. In the absence of such documentation, the currently requested Naprosyn is not medically necessary.