

<b>Case Number:</b>	CM15-0185061		
<b>Date Assigned:</b>	09/25/2015	<b>Date of Injury:</b>	10/18/2006
<b>Decision Date:</b>	12/08/2015	<b>UR Denial Date:</b>	09/03/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/21/2015

### 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: New York

Certification(s)/Specialty: Pediatrics, Internal Medicine

### 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 injured worker is a 60 year old male who reported an industrial injury on 10-18-2006. His diagnoses, and or impressions, were noted to include: status-post micro-lumbar decompression surgery, right lumbar 3-4 and 4-5 (11-29-12); thoracic degenerative disc disease; and lumbar radiculopathy. No current electrodiagnostic or imaging studies were noted; magnetic resonance imaging studies of the thoracic and lumbar spine were said to be done on 9-17-2012 and electrodiagnostic studies of the bilateral upper extremities attempted on 5-11-2011, but he was unable to tolerate the study; and a current toxicology screening on 4-21-2015 was said to be consistent. His treatments were noted to include: 16 physical therapy sessions; 25 acupuncture treatments; 26 chiropractic treatments; medication management with toxicology studies; and rest from work (since 10-2007). The progress notes of 7-28-2015 reported a follow-up visit for: constant pain in his low back that radiated into his bilateral gluts and lower extremities, rated 6-7 out of 10, left / right, and pain in his feet and knees that increased with prolonged sitting or activity; an increase in left neck and knee pain, increased by prolonged standing and walking; difficulty sleeping; and for medication refill as they help his chronic problems, decreasing his pain by 25% and improved sleep. The objective findings were noted to include: he was awaiting authorization for more physical therapy for the lumbar spine; no acute distress; discomfort with sitting and standing, and lying supine during the examination; diffuse tenderness about the lumbar mid-line and bilateral para-spinal muscles, with decreased lumbar range of motion in all planes; and positive left straight leg raise. The physician's requests for treatment were noted to include additional physical therapy for his lumbar spine as the 8 sessions helped decrease his

overall pain, decreased muscle spasms, and improved function and ability to walk and perform activities of daily living. The Request for Authorization, dated 7-28-2015, was noted to include additional physical therapy, 2x a week for 4 weeks, for the lumbar spine. The Utilization Review of 9-1-2015 non-certified the request for 8 additional physical therapy sessions, 2x a week x4 weeks, for the lumbar spine.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Eight additional Physical Therapy, twice a week, for four weeks to the lumbar spine:**

Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Physical Therapy.

**Decision rationale:** Per ODG guidelines, physical therapy is recommended. There is strong evidence that physical methods, including exercise and return to normal activities, have the best long-term outcome in employees with low back pain. Direction from physical and occupational therapy providers can play a role in this, with the evidence supporting active therapy and not extensive use of passive modalities. The most effective strategy may be delivering individually designed exercise programs in a supervised format (for example, home exercises with regular therapist follow-up), encouraging adherence to achieve high dosage, and stretching and muscle-strengthening exercises seem to be the most effective types of exercises for treating chronic low back pain. Guidelines state that treatment of intervertebral disc disorders with myelopathy post-surgical treatment is to receive 48 visits over 18 weeks. The IW underwent surgery in 2012 and has been in physical therapy. There is no tally of the number of physical therapy visits already undergone nor the response to the therapy. Additionally, the request is outside the time frame allotted in the guidelines with no rationale for exceeding therapy guidelines. The request is not medically necessary and appropriate.

**Norco 10/325mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

**Decision rationale:** The IW has been on long term opioids, which is not recommended. Additionally, documentation did not include review and documentation of pain relief, functional status, appropriate medication use, and side effects. Pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; 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. This request is not medically necessary and appropriate.

**Trazodone 50mg #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Insomnia treatment.

**Decision rationale:** Per ODG pharmacological agents for insomnia should only be used after careful evaluation of potential causes of sleep disturbance for the etiology. Ambien is indicated for the short-term treatment of insomnia with difficulty of sleep onset (7-10 days). First-line treatment is recommended to be non-benzodiazepine sedative-hypnotics such as Ambien, Ambien CR, Sonata and Lunesta. Sedating antidepressants (e.g., amitriptyline, trazodone, mirtazapine) have also been used to treat insomnia; however, there is less evidence to support their use for insomnia (Buscemi, 2007) (Morin, 2007), but they may be an option in patients with coexisting depression. There was no mention in the case file of evaluation for insomnia or failure of first line treatment options. This request is not medically necessary and appropriate.

**Twelve sessions of Aquatic Therapy, twice a week, for six weeks to the right hip and bilateral knees: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip & Pelvis, Knee - Aquatic Therapy.

**Decision rationale:** Per ODG hip guidelines, aquatic therapy is recommended 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 in the cases of extreme obesity or osteoarthritis of the hip. Per ODG knee guidelines, aquatic therapy is recommended 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, especially deep water therapy with a floating belt as opposed to shallow water requiring weight bearing, so it is specifically recommended where reduced weight bearing is desirable, for example extreme obesity. Aquatic exercise appears to have some beneficial short-term effects for patients with hip and/or knee osteoarthritis while no long-term effects have been documented. Positive short-term effects include significantly less pain and improved physical function, strength, and quality of

life. Results suggest that aquatic exercise does not worsen the joint condition or result in injury. In patients with hip or knee arthritis, both aquatic and land based exercise programs appear to result in comparable outcomes for function, mobility or pooled indices. For people who have significant mobility or function limitations and are unable to exercise on land, aquatic exercise is a legitimate alternative that may enable people to successfully participate in exercise. For recommendations on the number of supervised visits, see Physical therapy guidelines. As the IW had already undergone numerous sessions of physical therapy without documented improvement and there was no notation as to why aquatic therapy would provide benefit. The request is not medically necessary and appropriate.