

Case Number:	CM15-0185936		
Date Assigned:	09/28/2015	Date of Injury:	09/23/2006
Decision Date:	11/23/2015	UR Denial Date:	08/24/2015
Priority:	Standard	Application Received:	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: California

Certification(s)/Specialty: Preventive Medicine, Occupational 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:

The injured worker is a 56 year old female with an industrial injury dated 09-23-2006. A review of the medical records indicates that the injured worker is undergoing treatment for status post work related left knee injury on 9-23-2006, status post work related neck and back injury on 07-16-2007, status post left knee arthroscopic surgery in 11-2006 with residual pain, status post right shoulder rotator cuff repair in 12-2007 with residual pain, status post right ankle fracture with open reduction internal fixation (ORIF) and plate and screws on 07-09-2009 with residual pain, lower lumbar spine degenerative disc disease and facet arthropathy, chronic low back pain with bilateral intermittent radicular pain, bilateral sacroiliac (SI) dysfunction, chronic cervicalgia probably degenerative disc disease, chronic pain at right knee and left ankle, probably degenerative joint disease, and chronic pain syndrome. According to the progress note dated 08-10-2015, the injured worker reported chronic pain at the low back, neck and bilateral knees and ankle. Pain level was 10 out of 10 on a visual analog scale (VAS). Objective findings (08-10-2015) revealed antalgic gait, inability to toe or heel walk due to pain, decreased range of motion in the cervical and lumbar spine due to pain, "questionable positive bilateral straight leg raises, positive impingement sign at the right shoulder, positive Patrick's test and positive compression test at bilateral sacroiliac joints. The injured worker had tenderness to palpitation at the cervical and lumbar paraspinal muscles, bilateral sacroiliac (SI), right shoulder, bilateral knees and bilateral ankles with muscle tightness. Treatment has included diagnostic studies, prescribed medications epidural steroid injection (ESI), physical therapy with last session in 2008, home exercise program and periodic follow up visits. The treatment plan included physical therapy,

medication management, continue home exercises and a follow up in one month. The treating physician reported that her urine narcotic test was very weak positive for opiate only. The treating physician prescribed Ultram 50 MG #60 Refills Unspecified, Baclofen 10 MG #60 Unspecified, Motrin 600 MG #90 Refills Unspecified, 6 physical therapy of the right shoulder 2x3, 6 physical therapy of the left knee 2x3 and 6 physical therapy of the lumbar spine 2x3. The utilization review dated 08-24-2015 non-certified the request for Ultram 50 MG #60 Refills Unspecified, Baclofen 10 MG #60 Unspecified, Motrin 600 MG #90 Refills Unspecified, 6 physical therapy of the right shoulder 2x3, 6 physical therapy of the left knee 2x3 and 6 physical therapy of the lumbar spine 2x3.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ultram 50 MG #60 Refills Unspecified: Overturned

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 for chronic pain.

Decision rationale: Guidelines state that Ultram is indicated for moderate to moderately severe pain. Guidelines further state the criteria for the use of opioids is the ongoing review and documentation of the patient's pain relief, functional status, appropriate medication use, and side effects. In this case, the medical necessity has been established for the patient's use of the requested Ultram as a first-line analgesic agent for pain relief for the patient's treatment of chronic pain as it is appropriate in this clinical setting. I am reversing the previous utilization review decision. Ultram 50 MG #60 Refills Unspecified is medically necessary.

Baclofen 10 MG #60 Unspecified: 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): Muscle relaxants (for pain).

Decision rationale: The MTUS recommends baclofen, a non-sedating muscle relaxant, with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. Baclofen may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, it shows no benefit beyond NSAIDs in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. Baclofen 10 MG #60 Unspecified is not medically necessary.

Motrin 600 MG #90 Refills Unspecified: Overturned

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): NSAIDs (non-steroidal anti-inflammatory drugs).

Decision rationale: The MTUS recommends NSAIDs at the lowest dose for the shortest period in patients with moderate to severe pain. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. At present, based on the records provided, and the evidence-based guideline review, the request is medically reasonable. I am reversing the previous utilization review decision. Motrin 600 MG #90 is medically necessary.

6 PT of The Right Shoulder 2x3: Overturned

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): Manual therapy & manipulation.

Decision rationale: The request is for 6 visits of physical therapy. The Chronic Pain Medical Treatment Guidelines allow for an initial 4-6 visits after which time there should be documented functional improvement prior to authorizing more visits. The request for 6 visits is in accordance with the MTUS as appropriate to establish whether the treatment is effective. I am reversing the previous utilization review. 6 PT of The Right Shoulder 2x3 is medically necessary.

6 PT of The Left Knee 2x3: Overturned

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): Manual therapy & manipulation.

Decision rationale: The request is for 6 visits of physical therapy. The Chronic Pain Medical Treatment Guidelines allow for an initial 4-6 visits after which time there should be documented functional improvement prior to authorizing more visits. The request for 6 visits is in accordance with the MTUS as appropriate to establish whether the treatment is effective. I am reversing the previous utilization review. 6 PT of The left knee 2x3 is medically necessary.

6 PT of The Lumbar Spine 2x3: Overturned

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): Manual therapy & manipulation.

Decision rationale: The request is for 6 visits of physical therapy. The Chronic Pain Medical Treatment Guidelines allow for an initial 4-6 visits after which time there should be documented functional improvement prior to authorizing more visits. The request for 6 visits is in accordance with the MTUS as appropriate to establish whether the treatment is effective. I am reversing the previous utilization review. 6 PT of The Lumbar Spine 2x3 is medically necessary.