MAXIMUS Federal Services

Case Number:	CM15-0193651		
Date Assigned:	10/07/2015	Date of Injury:	03/01/2014
Decision Date:	11/23/2015	UR Denial Date:	09/24/2015
Priority:	Standard	Application Received:	10/01/2015

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: Texas, California
Certification(s)/Specialty: Family Practice

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 45 year old male with an industrial injury date of 03-01-2014. Medical record review indicates he is being treated for status post left shoulder rotator cuff repair and biceps tenodesis, lumbar strain-sprain, lumbar degenerative disc disease, lumbar radiculopathy, lumbar spondylosis and lumbar stenosis. Subjective complaints (08-05-2015) included low back pain rated as 1-6 out of 10. The treating physician indicated the injured worker reported "continued improvement." "He feels at least 85% better." Physical examination of the lumbar spine revealed tenderness on palpation, limited range of motion. "Medications as well as physical therapy learned exercises are proving effective in improving patient's pain levels, function, and range of motion and overall sense of comfort." The treating physician indicates medications (Gabapentin and Ultram ER) allowed the injured worker to sleep and perform routine activities of daily living and exercise, physical therapy learned exercises, daily walking (about 5 blocks) and going to the gym 3 days a week. The treating physician noted left leg symptoms persisted but were improved with Gabapentin. Work status (09-15-2015) is documented as off work. In the 09-15-2015 treatment note the injured worker was post epidural injection. The treating physician noted the injection provided "significant relief" with a pain rating of 3-4 out of 10. Medications (09-15-2015) included Tramadol, Cyclobenzaprine, Ibuprofen and Gabapentin. Prior treatments included at least 39 visits of physical therapy. Prior medications included Norco, Mobic, Naprosyn, Flexeril, Gabapentin and Tramadol ER. Objective findings (08-05-2015) included intact neuro circulatory status of the shoulder. There was rotator cuff and biceps weakness at 4 plus-five. Lumbar motion was guarded due to pain. The treating physician documented the injured worker was alert and oriented times three. "He

presents with no aberrant behaviors, signs of addiction nor miss use of these medications." He reports continued benefit with reduced pain and improved function in taking these medications. He denies any side effects. The treatment plan included physical therapy with the treating physician noting the injured worker's last physical therapy was focused to his shoulder after repair and with limitations on back care. "Patient wishes to have further instruction for his back as he is improving with his activity and wants preparation for his returning back to work at full duty." The patient's surgical history includes left shoulder surgery in 11/17/2014. Patient had received lumbar ESI on 8/27/15 for this injury. The patient sustained the injury due to MVA. The patient has had MRI of the lumbar spine on 6/29/14 that revealed disc protrusions, foraminal narrowing, and degenerative changes. A recent urine drug screen report was not specified in the records provided. Per the note dated 9/15/15 previous PT visits were focused to left shoulder following surgery and patient wishes 3-4 PT visits for back to have better instruction for HEP. Patient was prescribed Tylenol#3 as a trial to keep patient from using Hydrocodone or other strong Opioid. Per the note dated 9/15/15 the patient had complaints of low back pain at 3-4/10. Physical examination of the lumbar spine revealed mild discomfort, and 5/5 strength. A recent urine drug screen report was not specified in the records provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy, with heat stimulation, 1-2 times weekly, 4 visits: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back, Lumbar & Thoracic (Acute & Chronic) - Physical/Occupational therapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back (updated 09/22/15) Physical therapy.

Decision rationale: Request: Q Physical therapy, with heat stimulation, 1-2 times weekly, 4 visits. The guidelines cited below state, allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home physical medicine. ODG guideline recommends 1-2 visits over 1 week for this diagnosis as cited below. This is a request for Physical therapy, with heat stimulation, 1-2 times weekly, 4 visits. Hence the requested PT visits are more than the cited guideline. The patient has received at least 39 visits of physical therapy for this injury. The requested additional visits in addition to the previously certified PT sessions are more than recommended by the cited criteria. The records submitted contain no accompanying current PT evaluation for this patient. There was no evidence of ongoing significant progressive functional improvement from the previous PT visits that is documented in the records provided. Therapies at home as an extension of the treatment process in order to maintain improvement levels. A valid rationale as to why remaining rehabilitation cannot be accomplished in the context of an independent exercise program is not specified in the records provided. The medical necessity of the request for Physical therapy, with heat stimulation, 1-2 times weekly, 4 visits is not medically necessary for this patient.

Tylenol #3, Qty 60, 1 tab 2 times daily: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Codeine, Opioids for chronic pain, Opioids for neuropathic pain.

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

Decision rationale: Tylenol #3, Qty 60, 1 tab 2 times daily this is an opioid analgesic. According to CA MTUS guidelines cited below, a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals. The records provided do not specify that patient has set goals regarding the use of opioid analgesic. A treatment failure with non-opioid analgesics is not specified in the records provided. Other criteria for ongoing management of opioids are: The lowest possible dose should be prescribed to improve pain and function. Continuing review of the overall situation with regard to nonopioid means of pain control. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Consider the use of a urine drug screen to assess for the use or the presence of illegal drugs. The records provided do not provide a documentation of response in regards to pain control and functional improvement to opioid analgesic for this patient. The continued review of overall situation with regard to nonopioid means of pain control is not documented in the records provided. As recommended by MTUS a documentation of pain relief, functional status, appropriate medication use, and side effects should be maintained for ongoing management of opioid analgesic, these are not specified in the records provided. MTUS guidelines also recommend urine drug screen to assess for the use or the presence of illegal drugs in patients using opioids for long term. A recent urine drug screen report is not specified in the records provided. Whether improvement in pain translated into objective functional improvement including ability to work is not specified in the records provided. With this, it is deemed that, this patient does not meet criteria for ongoing continued use of opioids analgesic. The medical necessity of Tylenol #3, Qty 60, 1 tab 2 times daily is not established for this patient, given the records submitted and the guidelines referenced. If this medication is discontinued, the medication should be tapered, according to the discretion of the treating provider, to prevent withdrawal symptoms.