

<b>Case Number:</b>	CM15-0217444		
<b>Date Assigned:</b>	11/09/2015	<b>Date of Injury:</b>	08/11/2011
<b>Decision Date:</b>	12/28/2015	<b>UR Denial Date:</b>	10/07/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/04/2015

### 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, District of Columbia, Maryland  
 Certification(s)/Specialty: Anesthesiology, 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 39 year old male who sustained an industrial injury on August 11, 2011. The worker had been previously deemed as permanent and stationary. The worker is being treated for: status post laminectomy and discectomy with residual left leg radiculopathy; right shoulder arthroscopy July 2012, impingement syndrome improved and lumbar strain with spasm. Subjective: August 05, 2015 he reported complaint of having a steading increase in lower back pain with frequent spasm. He states being unable to perform previous HEP and has ran out of medications. Objective: August 05, 2015 noted the lumbar spine with mild tenderness to palpation of paraspinals left side greater, and trace spasm; flexion and extension mildly limited at 60 and 10 degrees; diminished light touch sensation left leg L5 distribution. Medication: August 05, 2015: Voltaren, Tramadol, and Robaxin. Treatment: medications, HEP, PT (several years past that was noted helpful). On October 01, 2015 a request was made for 8 sessions of physical therapy to lumbar spine, Robaxin 500mg #30, and Voltaren gel 1% #60 that were all noncertified by Utilization Review on October 07, 2015.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy, lumbar spine, 2 times weekly for 4 weeks, 8 sessions: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

**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 MTUS CPMTG, physical medicine guidelines 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." The ODG Preface specifies Physical Therapy Guidelines, "There are a number of overall physical therapy philosophies that may not be specifically mentioned within each guideline: (1) As time goes by, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency; (2) The exclusive use of "passive care" (e.g., palliative modalities) is not recommended; (3) Home programs should be initiated with the first therapy session and must include ongoing assessments of compliance as well as upgrades to the program; (4) Use of self-directed home therapy will facilitate the fading of treatment frequency, from several visits per week at the initiation of therapy to much less towards the end; (5) Patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy); & (6) When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted." Per the ODG guidelines: Lumbar sprains and strains (ICD9 847.2):10 visits over 8 weeks Per the medical records submitted for review, it was noted that the injured worker completed 8 physical therapy sessions in 2014. It was noted that physical therapy was previously helpful. As the injured worker has not had any physical therapy in greater than a year, physical therapy may be indicated. However, per the guidelines "patients should be formally assessed after a 'six-visit' clinical trial" to determine whether continuing with physical therapy is appropriate. The request for 8 visits is not appropriate. The request is not medically necessary.

**Robaxin 500 mg Qty 30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

**Decision rationale:** MTUS CPMTG recommends non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. The documentation submitted for review indicates that the injured worker has been using this medication since at least 8/2015. There is no documentation of the patients' specific functional level or percent improvement with treatment with Robaxin. As it is recommended only for short-term use, medical necessity cannot be affirmed.

**Voltaren 1% gel, Qty 60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines: Pain (Chronic) - Diclofenac, topical.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**Decision rationale:** With regard to topical NSAIDs, MTUS states "These medications may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. (Mason, 2004) Indications: Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks)." There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Voltaren Gel 1% specifically is "Indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist)." Per the guidelines, the indications of this medication are limited to joints that are amenable to topical treatment. The documentation submitted for review does not denote any indications for the request. The request is not medically necessary.