

<b>Case Number:</b>	CM15-0051695		
<b>Date Assigned:</b>	03/25/2015	<b>Date of Injury:</b>	05/29/2013
<b>Decision Date:</b>	05/05/2015	<b>UR Denial Date:</b>	03/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/18/2015

### 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, New York, 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 applicant is a represented 50-year-old who has filed a claim for chronic low back and knee pain reportedly associated with an industrial injury of May 29, 2013. In a Utilization Review report dated March 5, 2015, the claims administrator failed to approve a request for an electric heating pad, physical therapy, and Tylenol. A progress note dated February 11, 2015 and a RFA form dated February 27, 2015 were referenced in the determination. The applicant's attorney subsequently appealed. In a progress note dated March 18, 2015, the applicant reported ongoing complaints of low back pain, 8/10. The applicant was using tizanidine, Naprosyn, Tylenol, and tramadol, it was acknowledged. The applicant stated that his ability to concentrate and interact with others was limited secondary to pain, as were other activities such as driving. A rather proscriptive 10-pound lifting limitation was endorsed while Naprosyn and tramadol were renewed. It did not appear that the applicant was working with said limitation in place, although this was not explicitly stated. In a progress note dated February 20, 2015, the applicant reported 7-8/10 low back and knee pain complaints. The applicant's sleep, enjoyment of life, ability to exercise, ability to sit and walk, etc., were all limited to secondary to pain. The applicant was given a knee brace and a rather proscriptive 10-pound lifting limitation. Both Tylenol and tramadol were renewed. Additional physical therapy and custom orthosis were seemingly endorsed. On February 11, 2015, Tylenol was renewed while 12 sessions of therapy were proposed. The same, unchanged, rather proscriptive 10-pound lifting limitation was, once again, renewed.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Electric heating pad for chair:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG-TWC), Low back procedure summary.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299.

**Decision rationale:** Yes, the request for an electric heating pad was medically necessary, medically appropriate, and indicated here. The applicant's primary pain generator here was the low back. The MTUS Guideline in ACOEM Chapter 12, Table 12-5, page 299, notes that at-home local applications of heat and cold are recommended as methods of symptom control for low back pain complaints, as were/are present here. Given its low risk, usage of a heating pad was, thus, indicated here. Therefore, the request was medically necessary.

### **Physical therapy for the lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 98-99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Approach to Chronic Pain Management; Physical Medicine Guidelines Page(s): 8; 99.

**Decision rationale:** Conversely, the request for 12 sessions of physical therapy for the lumbar spine was not medically necessary, medically appropriate, or indicated here. The 12-session course of therapy proposed, in and of itself, represents treatment in excess of the 9- to 10-session course recommended on page 99 of the MTUS Chronic Pain Medical Treatment Guidelines for myalgias and myositis of various body parts. This recommendation is further qualified by commentary made on page 8 of the MTUS Chronic Pain Medical Treatment Guidelines to the effect that demonstration of functional improvement is necessary at various milestones in the treatment program in order to justify continued treatment. Here, however, the applicant was seemingly off of work as of the date of the request. The applicant had failed to profit from earlier physical therapy, it was suggested on several progress notes, referenced above. Pain complaints as high as 7 to 8/10 were reported, despite receipt of earlier unspecified amounts of physical therapy. Earlier physical therapy had failed to curtail the applicant's dependence on opioids and non-opioids agents such as tramadol, Naprosyn, tizanidine, etc. The same, unchanged, 10-pound lifting limitation was renewed from visit to visit. All of the foregoing, taken together, suggested a lack of functional improvement as defined in MTUS 9792.20f, despite receipt of earlier physical therapy in unspecified amounts. Therefore, the request for additional physical therapy was not medically necessary.

**Tylenol extra strength 500 mg #90:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Acetaminophen (APAP); Nonprescription medications Page(s): 11; 60.

**Decision rationale:** Finally, the request over-the-counter Tylenol (acetaminophen) was medically necessary, medically appropriate, and indicated here. As noted on page 11 of the MTUS Chronic Pain Medical Treatment Guidelines, Tylenol or acetaminophen is recommended in the chronic pain context present here. Page 60 of the MTUS Chronic Pain Medical Treatment Guidelines also recommends non-prescription medications, given the low risk and inexpensive cost. Here, continuing Tylenol did appear to be appropriate, given the applicant's continued complaints of low back and knee pain. Therefore, the request was medically necessary.