

<b>Case Number:</b>	CM15-0052558		
<b>Date Assigned:</b>	03/26/2015	<b>Date of Injury:</b>	03/17/2000
<b>Decision Date:</b>	05/13/2015	<b>UR Denial Date:</b>	02/18/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/19/2015

### 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, Washington

Certification(s)/Specialty: Physical Medicine & Rehabilitation, 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 52-year-old male who reported an injury on 03/17/2000. The mechanism of injury was not specifically stated. The current diagnoses include status post anterior lumbar interbody fusion on 07/22/2002, chronic lumbar sprain with postoperative radicular complaints, and status post left knee arthroscopy on 12/17/2008. The latest physician's progress report submitted for this review was documented on 01/08/2015. The injured worker presented for a follow-up evaluation. The injured worker indicated the prescription for Tylenol No. 3 does not help with pain control. The injured worker had worsening lumbar spine complaints. Radiating symptoms into the bilateral lower extremities with numbness and tingling were also reported. The injured worker reported spasm across the lumbar spine and intermittent left knee pain. The provider noted the injured worker had fallen twice since the previous visit secondary to weakness and locking of the knee. The injured worker also had symptoms of swelling, occasional popping, clicking, and weakness. Upon examination of the lumbar spine, there were 30 degrees forward flexion, 0 degrees extension, 10 degrees right lateral flexion, 5 degrees left lateral flexion, a positive straight leg raise on the left, and a left sided antalgic gait. The injured worker utilized a cane for ambulation assistance. Upon examination of the left knee, there were 0 to 120 degrees range of motion with a positive McMurray's sign. There was patellofemoral crepitus and medial joint line tenderness noted along with quadriceps atrophy. Recommendations at that time included a continuation of the current medication regimen and a follow-up evaluation in 2 to 3 months. A course of physical therapy for the lumbar spine and left knee was also recommended.

The injured worker was issued a left knee brace for support. There was no Request for Authorization form submitted for this review.

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

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

#### **12 Sessions PF Physical Therapy , Lumbar Spine And Left Knee: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

**Decision rationale:** The California MTUS Guidelines state active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. In this case, there was no documentation of a previous course of physical therapy with evidence of objective functional improvement to support the necessity for additional treatment. Therefore, the current request cannot be determined as medically necessary at this time.

#### **(1) Prescription of Ultram ER 150MG #30: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

**Decision rationale:** The California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. In this case, it was noted that the injured worker had failed to respond to Tylenol No. 3. However, there was no documentation of a written consent or agreement for chronic use of an opioid. Previous urine toxicology reports documenting evidence of patient compliance and nonaberrant behavior were not provided. There was also no frequency listed in the request. As such, the request is not medically necessary.

#### **(1) Prescription of Soma 350mg #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Carisprodol, NSAIDs, GI symptoms & cardiovascular risk.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66.

**Decision rationale:** The California MTUS Guidelines state muscle relaxants are recommended as non-sedating second line options for short term treatment of acute exacerbations. Soma should not be used for longer than 2 to 3 weeks. The injured worker has continuously utilized the above medication. However, there was documentation of moderate spasm in the paralumbar musculature upon examination. There was no documentation of objective functional improvement. There was also no frequency listed in the request. As such, the request is not medically necessary.

**(1) Prescription of Terocin cream 120ml: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

**Decision rationale:** The California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. In this case, there was no documentation of a failure of first line oral medication prior to the initiation of a topical analgesic. There was also no frequency listed in the request. As such, the request is not medically necessary.