

<b>Case Number:</b>	CM15-0087394		
<b>Date Assigned:</b>	05/11/2015	<b>Date of Injury:</b>	10/14/2013
<b>Decision Date:</b>	06/17/2015	<b>UR Denial Date:</b>	04/28/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/06/2015

### 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: Pennsylvania  
 Certification(s)/Specialty: Internal 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 51 year old male who sustained an industrial injury on 10/14/13 due to a fall from a roof. The injured worker was diagnosed as lumbar radiculopathy, status post L2 burst fracture/lumbar compression fracture, degenerative disc disease, and left knee strain/contusion with probable medial meniscal tear, left knee pain, and status post open reduction and internal fixation of forefoot fractures of the right foot with subsequent removal of hardware. Previous treatments included use of a cane, right foot surgery, medications, physical therapy, and chiropractic treatments. Previous diagnostic studies included magnetic resonance imaging. Progress note of 11/5/14 noted that the injured worker had approximately 12 visits of land-based physical therapy in the past. Aquatic therapy was requested. Work status was noted as temporarily totally disabled. The treating physician documented that the injured worker was advised to stop taking anti-inflammatory medication because of blood pressure issues. Hydrocodone was refilled. Toxicology study from 8/4/14 was noted to be consistent. On 11/25/14, a spine specialist recommended epidural steroid injection. In January 2015, it was noted that hydrocodone was not controlling pain. In February 2015, the treating physician noted that aquatic therapy was denied, and the physician stated it would be very helpful given the injured worker's antalgic gait and multiple lower extremity complaints. It was noted that the injured worker does not take anti-inflammatory medication due to hypertension. Continued use of hydrocodone was noted. Work status remained temporarily totally disabled. At a visit on 3/10/15 with a pain management consultant, the injured worker reported complaints of lower back pain with radiation to the lower extremities with associated numbness. The injured

worker's pain level was noted as 5/10 with medications and 7/10 without medications. Physical examination was notable for an antalgic gait, tenderness noted to the lumbar spine with limited range of motion, decreased sensation along the L5 dermatome in the right lower extremity, positive seated straight leg raise on the right, and tenderness noted to the left knee as well as mild swelling. The plan of care was for medication prescriptions and aqua therapy. The physician noted that reduced weight bearing is desirable, that functional limitations exist which would reduce the effectiveness of land based therapy, and that the injured worker would benefit from the buoyant effect of aquatic therapy due to chronic left knee pain and obesity. Norco was discontinued, and diclofenac and tramadol were prescribed. At a follow up visit on 4/7/15, the injured worker reported continued low back pain and left knee pain, which was noted to be unchanged since the last visit. Pain was rated 4/10 in severity with medications. Ongoing limitations in activities of daily living were noted including self-care and hygiene, activity, and ambulation. It was noted that medications and aquatic therapy had been denied. Aquatic therapy due to need for reduced weight bearing, failure of prior land therapy and obesity was requested. Diclofenac and tramadol were again requested; it was noted that hydrocodone was prescribed by another physician. Work status in April 2015 remained temporarily totally disabled. On 4/28/15, Utilization Review (UR) modified requests for the items currently under Independent Medical Review, citing the MTUS.

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

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

#### **Aqua Therapy 2x4 for the left knee: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic therapy; Physical Medicine Page(s): 22, 98-99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines aquatic therapy, physical medicine Page(s): 22, 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter: physical medicine treatment.

**Decision rationale:** The MTUS states that aquatic therapy is recommended as an optional form of exercise therapy as an alternative to land-based physical therapy when reduced weight bearing/minimization of the effects of gravity is desirable. Such situations include extreme obesity, and in certain cases of knee complaints while allowing the affected knee to rest before undergoing specific exercises to rehabilitate the area at a later date. Water exercises have been noted to improve some components of health-related quality of life, balance, and stair climbing in the treatment of fibromyalgia, but regular exercises and higher intensities may be required to preserve most of these gains. The number of sessions of aquatic therapy follows the physical medicine guidelines. The ODG states that patients should be formally assessed after a six visit clinical trial to evaluate whether physical therapy has resulted in positive impact, no impact, or negative impact prior to continuing with or modifying the physical therapy. Both the MTUS and ODG note that the maximum number of sessions for unspecified myalgia and myositis is 9-10 visits over 8 weeks, and 8-10 visits over 4 weeks for neuralgia, neuritis, and radiculitis. In this case, the injured worker was noted to have chronic back and knee pain. There was documentation of failure of prior land-based physical therapy, need for reduced weight bearing, functional limitations which would limit the effectiveness of land-based therapy, and obesity. As such, aquatic therapy would be indicated. However, the number of sessions requested (eight) is in excess of the guideline recommendation of an initial trial of six visits. As such, the request for Aqua Therapy 2x4 for the left knee is not medically necessary.

**Aqua Therapy 2x4 for the lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic Therapy, Physical Therapy Page(s): 22, 98-99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines aquatic therapy, physical medicine Page(s): 22, 98-99.

**Decision rationale:** The MTUS states that aquatic therapy is recommended as an optional form of exercise therapy as an alternative to land-based physical therapy when reduced weight bearing/minimization of the effects of gravity is desirable. Such situations include extreme obesity, and in certain cases of knee complaints while allowing the affected knee to rest before undergoing specific exercises to rehabilitate the area at a later date. Water exercises have been noted to improve some components of health-related quality of life, balance, and stair climbing in the treatment of fibromyalgia, but regular exercises and higher intensities may be required to preserve most of these gains. The number of sessions of aquatic therapy follows the physical medicine guidelines. The ODG states that patients should be formally assessed after a six visit clinical trial to evaluate whether physical therapy has resulted in positive impact, no impact, or negative impact prior to continuing with or modifying the physical therapy. Both the MTUS and ODG note that the maximum number of sessions for unspecified myalgia and myositis is 9-10 visits over 8 weeks, and 8-10 visits over 4 weeks for neuralgia, neuritis, and radiculitis. In this case, the injured worker was noted to have chronic back and knee pain. There was documentation of failure of prior land-based physical therapy, need for reduced weight bearing, functional limitations which would limit the effectiveness of land-based therapy, and obesity. As such, aquatic therapy would be indicated. However, the number of sessions requested (eight) is in excess of the guideline recommendation of an initial trial of six visits. As such, the request for Aqua Therapy 2x4 for the lumbar spine is not medically necessary.

**Diclofenac Sod ER 100mg #30:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Inflammatory Medications Page(s): 22.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67-73.

**Decision rationale:** This injured worker has chronic back and knee pain. Per the MTUS, non-steroidal anti-inflammatory drugs (NSAIDs) are recommended as a second line treatment after acetaminophen for treatment of acute exacerbations of chronic back pain. The MTUS does not specifically reference the use of NSAIDs for long-term treatment of chronic pain in other specific body parts. NSAIDs are noted to have adverse effects including gastrointestinal side

effects and increased cardiovascular risk; besides these well-documented side effects of NSAIDs, NSAIDs have been shown to possibly delay and hamper healing in all the soft tissues including muscles, ligaments, tendons, and cartilage. NSAIDs can increase blood pressure and may cause fluid retention, edema, and congestive heart failure; all NSAIDs are relatively contraindicated in patients with renal insufficiency, congestive heart failure, or volume excess. They are recommended at the lowest dose for the shortest possible period in patients with moderate to severe pain. The MTUS does not recommend chronic NSAIDs for low back pain, NSAIDs should be used for the short term only. Systemic toxicity is possible with NSAIDs. The FDA and MTUS recommend monitoring of blood tests and blood pressure. In this case, diclofenac was prescribed by the pain management consultant. The primary treating physician documented on multiple occasions that the injured worker should not take anti-inflammatory medication due to hypertension. As NSAIDs are not recommended chronically for the treatment of low back pain, and as the primary treating physician has consistently documented a contraindication to NSAIDs, the requests for diclofenac is not medically necessary.

**Tramadol 50mg, #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines opioids Page(s): 74-96.

**Decision rationale:** This injured worker has chronic back and knee pain. Hydrocodone was prescribed for at least five months, and the documentation suggests that opioid use has been ongoing for more than 8 months. Tramadol is a centrally acting synthetic opioid analgesic, which is not recommended as a first line oral analgesic. Multiple side effects have been reported including increased risk of seizure especially in patients taking selective serotonin reuptake inhibitors (SSRIs), tricyclic antidepressants (TCAs) and other opioids. It may also produce life-threatening serotonin syndrome. There is insufficient evidence that the treating physician is prescribing opioids according to the MTUS, which recommends prescribing according to function, with specific functional goals, return to work, random drug testing, and opioid contract. An opioid contract and functional goals were not discussed. Work status has been documented as temporarily totally disabled. Per the MTUS, opioids are minimally indicated, if at all, for chronic non-specific pain, osteoarthritis, "mechanical and compressive etiologies," and chronic back pain. There is no evidence of significant pain relief or increased function from the opioids used to date. The MTUS states that a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. There is no evidence that the treating physician has utilized a treatment plan NOT using opioids, and that the patient "has failed a trial of non-opioid analgesics." Ongoing management should reflect four domains of monitoring, including analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors. The documentation does not reflect improvement in pain. Change in activities of daily living, and screening for aberrant drug-taking behaviors were not documented. The MTUS recommends urine drug screens for patients with poor pain control and to help manage patients at risk of abuse. There is no record of a urine drug screen program performed according to quality criteria in the MTUS and other guidelines. One toxicology report was mentioned but specific results

were not submitted. The records show that this injured worker is receiving opioids from more than one physician. The MTUS recommends that patients receive their medication from one physician and one pharmacy. As currently prescribed, Tramadol does not meet the criteria for long term opioids as elaborated in the MTUS and is therefore not medically necessary.