

Case Number:	CM14-0141019		
Date Assigned:	09/10/2014	Date of Injury:	07/31/2013
Decision Date:	11/28/2014	UR Denial Date:	08/15/2014
Priority:	Standard	Application Received:	09/02/2014

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. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

According to the records made available for review, this is a 27-year-old male with a 7/31/13 date of injury. At the time (7/29/14) of request for authorization for Physical Therapy 2 times per week for 6 weeks, Ketoprofen, Gabapentin, Tramadol Cream (quantity unknown), Sleep Study, Xanax 1 mg #60, Norflex 100 mg #60, and Urine Toxicology Screening, there is documentation of subjective (ongoing moderate low back pain, moderate left hip pain, trouble sleeping, and moderate left knee pain) and objective (decreased lumbar and hip range of motion) findings, current diagnoses (lumbar sprain/strain, lumbar degenerative disc disease, lumbar herniated nucleus pulposus, left hip contusion, left hip old deformity, anxiety, insomnia, and left knee sprain/strain), and treatment to date (physical therapy (unknown amount) with pain relief; and ongoing treatment with Norflex, Tramadol, Xanax, and Naprosyn). Regarding Physical Therapy 2 times per week for 6 weeks, the number of previous physical therapy treatments cannot be determined; and there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services as a result of physical therapy provided to date. Regarding Sleep Study, there is no documentation of excessive daytime somnolence; cataplexy (muscular weakness usually brought on by excitement or emotion, virtually unique to narcolepsy); morning headache (other causes have been ruled out); intellectual deterioration (sudden, without suspicion of organic dementia); personality change (not secondary to medication, cerebral mass or known psychiatric problems); sleep-related breathing disorder or periodic limb movement disorder is suspected; and/or insomnia complaint for at least six months (at least four nights of the week), unresponsive to behavior intervention and sedative/sleep-promoting medications and psychiatric etiology has been excluded. Regarding Xanax 1 mg #60, there is no documentation of short-term (less than 4 weeks) treatment and functional benefit or improvement as a reduction in work restrictions; an

increase in activity tolerance; and/or a reduction in the use of medications as a result of Xanax use to date. Regarding Norflex 100 mg #60, there is no documentation of acute exacerbation of chronic low back pain, short-term (less than two weeks) treatment, and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Norflex use to date. Regarding Urine Toxicology Screening, there is no documentation of abuse, addiction, or poor pain control.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy 2 times per week for 6 weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back; Knee, Physical therapy Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines support a brief course of physical medicine for patients with chronic pain not to exceed 10 visits over 4-8 weeks with allowance for fading of treatment frequency, with transition to an active self-directed program of independent home physical medicine/therapeutic exercise. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG recommends a limited course of physical therapy for patients with a diagnosis of lumbar and knee sprain/strain not to exceed 12 visits over 8 weeks. ODG also notes 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) and when treatment requests exceeds guideline recommendations, the physician must provide a statement of exceptional factors to justify going outside of guideline parameters. Within the medical information available for review, there is documentation of diagnoses of lumbar sprain/strain, lumbar degenerative disc disease, lumbar herniated nucleus pulposus, left hip contusion, left hip old deformity, anxiety, insomnia, and left knee sprain/strain. In addition, there is documentation of previous physical therapy. However, there is no documentation of the number of previous physical therapy treatments and, if the number of treatments have exceeded guidelines, remaining functional deficits that would be considered exceptional factors to justify exceeding guidelines. In addition, despite documentation of pain relief with physical therapy, there is no (clear) documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services as a result of physical therapy provided to date. Therefore, based on guidelines and a review of the evidence, the request for Physical Therapy 2 times per week for 6 weeks is not medically necessary.

Ketoprofen, Gabapentin , Tramadol Cream (quantity unknown): Upheld

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

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

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that many agents are compounded as monotherapy or in combination for pain control; that ketoprofen, lidocaine (in creams, lotion or gels), capsaicin in a 0.0375% formulation, baclofen and other muscle relaxants, and gabapentin and other antiepilepsy drugs are not recommended for topical applications; and that any compounded product that contains at least one drug (or drug class) that is not recommended, is not recommended. Within the medical information available for review, there is documentation of diagnoses of lumbar sprain/strain, lumbar degenerative disc disease, lumbar herniated nucleus pulposus, left hip contusion, left hip old deformity, anxiety, insomnia, and left knee sprain/strain. However, the requested compounded medication consists of at least one drug (ketoprofen and gabapentin) that is not recommended. In addition, there is no documentation of the quantity requested. Therefore, based on guidelines and a review of the evidence, the request for Ketoprofen, Gabapentin, Tramadol Cream (quantity unknown) is not medically necessary.

Sleep Study: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines -Treatment in Worker's Compensation,(last updated 05/15/2014), Polysomnography

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Polysomnography

Decision rationale: MTUS does not address this issue. ODG identifies documentation of excessive daytime somnolence; cataplexy (muscular weakness usually brought on by excitement or emotion, virtually unique to narcolepsy); morning headache (other causes have been ruled out); intellectual deterioration (sudden, without suspicion of organic dementia); personality change (not secondary to medication, cerebral mass or known psychiatric problems); sleep-related breathing disorder or periodic limb movement disorder is suspected; and/or insomnia complaint for at least six months (at least four nights of the week), unresponsive to behavior intervention and sedative/sleep-promoting medications and psychiatric etiology has been excluded, as criteria necessary to support the medical necessity of polysomnography. Within the medical information available for review, there is documentation of diagnoses of lumbar sprain/strain, lumbar degenerative disc disease, lumbar herniated nucleus pulposus, left hip contusion, left hip old deformity, anxiety, insomnia, and left knee sprain/strain. However, despite documentation of trouble sleeping, there is no documentation of excessive daytime somnolence; cataplexy (muscular weakness usually brought on by excitement or emotion, virtually unique to narcolepsy); morning headache (other causes have been ruled out); intellectual deterioration

(sudden, without suspicion of organic dementia); personality change (not secondary to medication, cerebral mass or known psychiatric problems); sleep-related breathing disorder or periodic limb movement disorder is suspected; and/or insomnia complaint for at least six months (at least four nights of the week), unresponsive to behavior intervention and sedative/sleep-promoting medications and psychiatric etiology has been excluded. Therefore, based on guidelines and a review of the evidence, the request for sleep study is not medically necessary.

Xanax 1 mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that benzodiazepines are not recommended for long-term use and that most guidelines limit use to 4 weeks. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of diagnoses of lumbar sprain/strain, lumbar degenerative disc disease, lumbar herniated nucleus pulposus, left hip contusion, left hip old deformity, anxiety, insomnia, and left knee sprain/strain. However, given documentation of ongoing treatment with Xanax, there is no documentation of short-term (less than 4 weeks) treatment. In addition, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Xanax use to date. Therefore, based on guidelines and a review of the evidence, the request for Xanax 1 mg #60 is not medically necessary.

Norflex 100 mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for Pain). Decision based on Non-MTUS Citation Official Disability Guidelines -Treatment in Worker's Compensation, Pain Procedure Summary,(last updated 10/14/2013), Non-sedating muscle relaxants

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-64. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Muscle relaxants (for pain) Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of acute exacerbation of chronic low back pain and used as a second line option for short-term treatment, as criteria necessary to support the medical necessity of muscle

relaxant. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies that muscle relaxants are recommended for short-term (less than two weeks) treatment. Within the medical information available for review, there is documentation of diagnoses of lumbar sprain/strain, lumbar degenerative disc disease, lumbar herniated nucleus pulposus, left hip contusion, left hip old deformity, anxiety, insomnia, and left knee sprain/strain. In addition, there is documentation of chronic low back pain. However, there is no documentation of acute exacerbation of chronic low back pain. In addition, given documentation of ongoing treatment with Norflex, there is no documentation of short-term (less than two weeks) treatment. Furthermore, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Norflex use to date. Therefore, based on guidelines and a review of the evidence, the request for Norflex 100 mg #60 is not medically necessary.

Urine Toxicology Screening: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines -Treatment in Worker's Compensation, Pain Procedure Summary, Urine Drug Testing (UDT)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines On-Going Management Page(s): 78.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of abuse, addiction, or poor pain control in patient under on-going opioid treatment, as criteria necessary to support the medical necessity of Urine Drug Screen. Within the medical information available for review, there is documentation of diagnoses of lumbar sprain/strain, lumbar degenerative disc disease, lumbar herniated nucleus pulposus, left hip contusion, left hip old deformity, anxiety, insomnia, and left knee sprain/strain. In addition, there is documentation of on-going opioid treatment. However, there is no documentation of abuse, addiction, or poor pain control. Therefore, based on guidelines and a review of the evidence, the request for Urine Toxicology Screening is not medically necessary.