

<b>Case Number:</b>	CM14-0160368		
<b>Date Assigned:</b>	10/06/2014	<b>Date of Injury:</b>	01/13/2008
<b>Decision Date:</b>	10/30/2014	<b>UR Denial Date:</b>	09/29/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/30/2014

### 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 Iowa. 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:

The patient is a 41 year old male with a date of injury of 1/13/2008. A review of the medical documentation indicates that the patient is undergoing treatment for chronic low back pain. Subjective complaints (9/11/2014) include low back pain of 7-8/10 and leg pain of 0-1/10 that has remained about the same from previous visits, as well as pain and difficulty with lifting, walking, standing, and daily duties. Objective findings (9/11/2014) include positive sacroiliac special tests (FABER, shear, PSIS), some pain with low back extension, and decreased lower extremity reflexes. Diagnoses include spondylosis L4-S1, herniated disc L5-S1, and sacroiliac joint dysfunction. There are no records of any imaging studies available for review. The patient has previously undergone multiple injections, although records of these were not available. A utilization review dated 9/29/2014 did not certify the request for Physical Therapy 2x6 weeks and Oxycontin 40 mg #90.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy 2x6 Wks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): ) 287-315, Chronic Pain Treatment Guidelines Physical Therapy, Physical Medicine,

Page(s): page(s) 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Physical Therapy

**Decision rationale:** According to MTUS guidelines, physical therapy is recommended for chronic pain when accompanied by a self-directed home physical medicine program. The guidelines recommend fading of treatment frequency (from 3 visits per week to 1 or less). ACOEM also recommends a home exercise program to accompany physical therapy. ODG recommends an initial therapy of 10 visits over 8 weeks for lumbar muscle issues, and 9 visits over 8 weeks for unspecified back pain. ODG recommends a six-visit clinical trial of physical therapy with documented objective and subjective improvements. The treating physician states the patient does not have a regular home exercise program, and one purpose of the therapy is to develop one. However, the amount of sessions is in excess of the recommended trial period, there is no fading of treatment frequency, and there is no documentation to support that past physical therapy has resulted in functional improvement. Therefore, the request for Physical Therapy 2 sessions x 6 weeks, is not medically necessary at this time.

**Oxycontin 40 Mg #90:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Specific Drug List Page(s): 92.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Page(s): page(s) 74-96. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Opioids

**Decision rationale:** OxyContin, is an opioid class pain medication. According to MTUS chronic pain guidelines, opioids should be used on a trial basis after failure of first-line therapies and re-evaluated regularly. The guidelines recommend ongoing review and documentation of pain relief, functional status, appropriate use, and side effects. Satisfactory response to treatment should be indicated including decreased pain, increased functional status, or improved quality of life. ODG guidelines do not recommend use of opioids for low back pain except in short use for severe cases, not to exceed two weeks. The patient appears to have been on this medication for several months, which is in excess of what would be considered short-term therapy. The treating physician has not provided rationale for the extended use of this medication, and the medical documentation does not contain evidence of functional improvement or documented trials and failures of first line therapies. The documentation states that the patient continues to have severe pain and decreased functional status despite this pain medication regimen. Therefore, the request for Oxycontin 40 mg #90 is not medically necessary.