

<b>Case Number:</b>	CM15-0016523		
<b>Date Assigned:</b>	02/05/2015	<b>Date of Injury:</b>	07/15/2010
<b>Decision Date:</b>	03/30/2015	<b>UR Denial Date:</b>	01/23/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/28/2015

### 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

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 34-year-old female who reported injury on 07/15/2010. The diagnoses included lumbar sprain/strain, neck sprain/strain, and thoracic sprain/strain. The injured worker was noted to be status post lumbar decompression. The mechanism of injury was the injured worker was standing in a bathtub scrubbing the walls when she slipped on the wet and soapy floor. Prior treatments included physical therapy, medications, heat, ice, epidural steroid injections and activity modification. The diagnostic studies included an MRI of the cervical spine without contrast. There was a Request for Authorization submitted for review dated 01/15/2015. The documentation of 12/10/2014 revealed the injured worker had low back pain and had no chiropractic to date. The injured worker had 12 sessions of physical therapy for the low back. The injured worker had thoracic pain. The injured worker was utilizing cyclobenzaprine. The documentation indicated the injured worker had spasms that remained refractory to stretching, heat, cold, activity modification, physical therapy, and home exercise. The documentation further indicated that the cyclobenzaprine at 7.5 mg 3 times a day facilitated a decrease in intractable spasms for the average of 5 hours and the injured worker had improved motion and tolerance to exercise and decreased pain level. The objective findings revealed tenderness in the cervical spine and limited range of motion. The request was made for chiropractic treatment for the lumbar spine at 3 times per week for 4 weeks. The injured worker was noted to have no chiropractic treatment to date. Initially, there was a continued request made for physical therapy for the thoracic spine at 3 times a week times 4 weeks. There was a request made for a new lumbar spine orthosis as the old one no longer fastened. Additionally,

the medications included tramadol ER 150 mg #60 two by mouth daily, pantoprazole 20 mg #90 one by mouth 3 times a day, cyclobenzaprine 7.5 mg 1 by mouth 3 times a day, and random urine toxicology screens.

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

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

**Chiropractic treatment for the lumbar spine, 3 times a week for 4 weeks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298 - 299, Chronic Pain Treatment Guidelines Page(s): 58.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy Page(s): 58, 59.

**Decision rationale:** The California Medical Treatment Utilization Schedule guidelines states that manual therapy and manipulation is recommended for chronic pain if caused by musculoskeletal conditions. For the low back, therapy is recommended initially in a therapeutic trial of 6 sessions and with objective functional improvement a total of up to 18 visits over 6-8 weeks may be appropriate. The clinical documentation submitted for review failed to indicate objective findings that would support the necessity for chiropractic manipulation. Additionally, the request for 12 sessions exceeds the initial treatment of 6 sessions. There was a lack of documentation indicating a necessity for 12 sessions. Given the above, the request for chiropractic treatment for the lumbar spine, 3 times a week for 4 weeks is not medically necessary.

**Retrospective Cyclobenzaprine 7.5 mg #90, dispensed on 12/10/2014: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Pain Chapter, Non-Sedating Muscle Relaxants

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

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines recommend muscle relaxants as a second line option for the short term treatment of acute low back pain. Their use is recommended for less than 3 weeks. There should be documentation of objective functional improvement. The clinical documentation submitted for review indicated the injured worker had utilized the medication for an extended duration of time. However, it further indicate the injured worker had spasms that were refractor to stretching, cold, heat, activity modification, physical therapy, and home exercise. Additionally, the injured worker was noted to have improved motion and tolerance to exercise and a decrease in pain level with the use of the medication. This medication would be supported. However, the request as submitted failed to indicate the frequency for the requested medication. Therefore, the request for retrospective cyclobenzaprine 7.5 mg #90 dispensed on 12/10/2014 was not medically necessary.

**Retrospective Pantoprazole 20mg #90, dispensed on 12/10/2014: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Pain Chapter, Proton Pump Inhibitors

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 69.

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines indicate that proton pump inhibitors are recommended for injured workers at intermediate or high risk for gastrointestinal events. Injured workers with no risk factor or cardiovascular disease do not require the use of proton pump inhibitors. The clinical documentation submitted for review failed to indicate the injured worker had been found to be at risk for gastrointestinal events. The injured worker was noted to utilize the medication for an extended duration of time. There was a lack of documented efficacy. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for retrospective pantoprazole 20 mg #90 dispensed 12/10/2014 is not medically necessary.

**Physical therapy for the thoracic spine, 3 times a week for 4 weeks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98 - 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): ([http:// www.odg-twc.com/preface.htm#PhysicalTherapyGuidelines](http://www.odg-twc.com/preface.htm#PhysicalTherapyGuidelines)) and Official Disability Guidelines (ODG): (Lumbar & Thoracic Back Chapter)

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

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines recommend physical medicine treatment for up to 10 visits for myalgia and myositis. The clinical documentation indicated the injured worker had previously undergone physical therapy; however, it was indicated the physical therapy was not for the thoracic spine. The request as submitted would exceed guideline recommendations. There was a lack of documentation of objective findings to support the injured worker had decreased range of motion specifically in the thoracic spine that would respond to conservative care. Given the above and the lack of documentation, the request for physical therapy for the thoracic spine, 3 times a week for 4 weeks is not medically necessary.