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| Case Number: | CM15-0114200 | | |
| Date Assigned: | 06/22/2015 | Date of Injury: | 02/08/2012 |
| Decision Date: | 07/24/2015 | UR Denial Date: | 05/20/2015 |
| Priority: | Standard | Application Received: | 06/12/2015 |

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 31 year old male who sustained a work related injury February 8, 2012. While working as a correctional office, he was involved in an altercation with an inmate, was elbowed in the face, and had two broken teeth from his partial denture. He reported immediate right knee pain and low back pain an hour later. Past history included a MLD (micro lumbar discectomy) 2012. According to a primary treating physician's progress report, dated April 15, 2015, the injured worker presented with complaints of low back and bilateral leg pain. His symptoms improved since the last visit. He reports a transforaminal epidural steroid injection left L5, S1 4/9/2015 with 100% relief of the left leg numbness. He does continue to have some low back pain, rated 5/10, described as stabbing and aching with radiation in his bilateral lower extremities, much greater on the left. He also reports increased mobility in the left leg. He is able to walk longer than 30 minutes, stand longer, can wear a belt and decreased Norco for 3 a day to 2 a day. There is pain in the right knee. Assessment is documented as chronic back pain, s/p MLD at L5 and S1; lumbar radiculopathy; lumbar facet arthropathy; lumbar myofascial pain; lumbago; piriformis syndrome; lumbar stenosis and degenerative disc disease. At issue, is a request for authorization for deep tissue massage for the lumbar spine and Ultracet.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ultracet 37.5/325mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram), When to Continue Opioids Page(s): 93-94, 113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 76-78, 88-89.

Decision rationale: The patient was injured on 02/08/12 and presents with low back pain and bilateral leg pain. The request is for ULTRACET 37.5/325 MG #60 for pain. The RFA is dated 04/15/15 and the patient's work status states that if no modified work is available, employer must keep employee off work unless, and until, such modified work is made available. Treatment reports are provided from 11/12/14 to 05/13/15 and the patient has been taking Ultracet as early as 03/17/15. MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument. MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief." On 03/17/15, he rated his pain as a 6- 7/10. "He continues to exercise and stretch at home to help manage his pain. Ultracet [provides] good relief of pain, allows him to walk longer, standing longer, bending forward and he is able to pick up his son." CURES report from 01/20/14 is consistent with medications prescribed. Urinalysis report from 12/10/14 is consistent. There are no signs of misuse/abuse/divergence/ addiction with the medications prescribed. The 04/15/15 report indicates that the patient rates his pain as a 5/10 and on 05/06/15, he rated his pain as an 8/10. In this case, the treater discusses ADLs; however, not all of the 4 As are addressed as required by MTUS Guidelines. Although the treater provides general pain scales, there are no before and after medication pain scales provided. There are no discussions provided on adverse behavior/side effects and no validated instruments are used either. No outcome measures are provided as required by MTUS Guidelines. The patient does have a CURES report on files and he was consistent with his urine drug screen. The treating physician does not provide proper documentation that is required by MTUS Guidelines for continued opiate use. Therefore, the requested Ultracet IS NOT medically necessary.

Deep tissue massage monthly for the lumbar spine: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Massage therapy Page(s): 60.

Decision rationale: The patient was injured on 02/08/12 and presents with low back pain and bilateral leg pain. The request is for DEEP TISSUE MASSAGE MONTHLY FOR THE LUMBAR SPINE "1 day per month for 6 months." The utilization review denial letter did not provide a rationale. The RFA is dated 04/15/15 and the patient's work status states that if no modified work is available, employer must keep employee off work unless, and until, such modified work is made available. There is no documentation of any prior deep tissue massage. MTUS Chronic Pain Medical Treatment Guidelines, page 60 for Massage therapy states: "Recommended as an option as indicated below. This treatment should be an adjunct to other recommended treatment (e.g. exercise), and it should be limited to 4-6 visits in most

cases." The patient has stabbing, aching low back pain which radiates to the bilateral lower extremities. He is diagnosed with status post microlumbar decompressive surgery bilaterally at L5-S1 (07/17/12), lumbar radiculopathy, lumbar disc herniations at L4-5 and L5-S1 with mild to severe neural foraminal narrowing, chronic back pain, lumbar facet arthropathy, lumbar myofascial pain, lumbago, piriformis syndrome, lumbar stenosis, and degenerative disc disease. The reason for the request is not provided. Given the patient's low back pain, a trial of 6 massage therapy sessions appears reasonable. The requested massage therapy IS medically necessary.