

<b>Case Number:</b>	CM15-0121571		
<b>Date Assigned:</b>	07/02/2015	<b>Date of Injury:</b>	06/23/1999
<b>Decision Date:</b>	08/10/2015	<b>UR Denial Date:</b>	05/29/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/23/2015

### 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: New York  
 Certification(s)/Specialty: Pediatrics, 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 46 year old female, who sustained an industrial injury on June 23, 1999 while working as a chart room clerk. The mechanism of injury was a fall in which she landed on her buttocks. The injured worker experienced low back pain and pain into her legs. The diagnoses have included lumbar spinal stenosis and lumbar degenerative disc disease. Treatment and evaluation to date has included medications, radiological studies, electrodiagnostic studies, back brace, physical therapy, psychiatric assessments and a lumbar-five, sacral-one fusion. Work status was noted to be permanent and stationary. Current documentation dated May 8, 2015 notes that the injured worker reported intermittent episodes of low back pain radiating to the anterior thigh region. Examination of the lumbar spine revealed movements of the spine to be painful. Motor strength was 5/5 bilaterally. The treating physician's plan of care included requests for physical therapy for the lumbar spine # 24 and Norco 10/325 mg # 180.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy for the lumbar spine, 24 sessions:** 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, 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back, Lumbar and Thoracic (acute and chronic).

**Decision rationale:** The California Medical Treatment Utilization Schedule (MTUS) Guidelines for chronic pain recommends up to 10 visits over 4 weeks of physical therapy for chronic pain. Chronic Pain Guidelines state that all therapies are focused on the goal of functional restoration rather than merely the elimination of pain and assessment of treatment efficacy is accomplished by restoring function improvement. The documentation supports the injured worker received at least 6 visits of physical therapy in 2013 and was participating in a home exercise program. There is no other documentation of previously administered physical therapy or any improvement from it. The injured worker continues to have intermittent chronic back. There was no documentation to supports a flare-up of symptoms. The Official Disability Guidelines (ODG) recommends 34 visits over 16 weeks for post-operatively for fusion once the graft has matured. The IW had undergone prior physical therapy and had been doing well up to 2 years after surgery. The IW's current symptoms would fall under the guidelines for radiculitis which recommends 10-12 visits over 8 weeks. Therefore, the current request for 24 physical therapy sessions exceeds MTUS and ODG Guidelines and is not medically necessary.

**Norco 10/325mg quantity 180:** Upheld

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

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

**Decision rationale:** The California Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines discourages long term usage unless there is evidence of "ongoing review and documentation of pain relief, functional status and appropriate medication use and side effects. Pain assessment should include: current pain, the least reported pain over the period since last assessment, average pain, the intensity of pain after taking the opioid, how long it takes for pain relief and how long the pain relief lasts. Satisfactory response to treatment may be indicated by the injured worker's decreased pain level, increased level of function or improved quality of life." Norco has been prescribed for this injured worker for at least five months, since January 2015. No functional improvement as a result of use of Norco was noted. There was no documentation of improvement in specific activities of daily living as a result of use of Norco. There was no documentation of decrease in medication use or decrease in frequency of office visits as a result of use of Norco. Due to lack of detailed pain assessment, lack of documentation of improvement in pain and lack of documentation of functional improvement, the request for Norco is not medically necessary.