

Case Number:	CM15-0179820		
Date Assigned:	09/28/2015	Date of Injury:	09/26/2014
Decision Date:	11/20/2015	UR Denial Date:	08/31/2015
Priority:	Standard	Application Received:	09/11/2015

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: Emergency 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:

This is a 27 year old female with a date of injury on 9-26-2014. A review of the medical records indicates that the injured worker is undergoing treatment for thoracic musculoligamentous sprain-strain and lumbosacral musculoligamentous sprain-strain with radiculitis. According to the progress report dated 7-30-2015, the injured worker complained of pain in the mid and upper back rated 7 out of 10 which was decreased from 8 out of 10 at the last visit. She also complained of low back pain rated 8 out of 10 which had decreased from 9 out of 10 on the last visit. Per the treating physician (7-30-2015), the injured worker was temporarily totally disabled. The physical exam (7-30-2015) revealed tenderness to palpation and spasm over the thoracic and lumbar paraspinal muscles. Straight leg raise test was positive bilaterally. Treatment has included at least 16 sessions of physical therapy, at least 5 sessions of chiropractic treatment, and medications. The request for authorization dated 7-30-2015 included physical therapy for the right shoulder, right elbow and right wrist, Tramadol and Theramine and continue physical therapy for evaluation and treatment of the thoracic spine and lumbar spine. The original Utilization Review (UR) (8-31-2015) denied requests for physical therapy for the lumbar spine 2 times a week for 6 weeks, physical therapy for the right wrist 1 time a week for 6 weeks, Tramadol and Theramine.

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 2 times a week for 6 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

Decision rationale: The request is for physical therapy to aid in pain relief. The MTUS guidelines states that manipulation is recommended for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. It is indicated for low back pain but not ankle and foot conditions, carpal tunnel syndrome, forearm/wrist/hand pain, or knee pain. The use of active treatment modalities instead of passive treatments is associated with substantially better clinical outcomes. (Fritz, 2007) Active treatments also allow for fading of treatment frequency along with active self-directed home PT, so that less visits would be required in uncomplicated cases. The guidelines state the following: Low back: Recommended as an option. Therapeutic care: Trial of 6 visits over weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. Elective/maintenance care: Not medically necessary. Recurrences/flare-ups: Need to reevaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months. Ankle & Foot: Not recommended. Carpal tunnel syndrome: Not recommended. Forearm, Wrist, & Hand: Not recommended. Knee: Not recommended. In this case, the patient does not qualify for physical therapy as indicated above and would benefit most from at home active therapy. As such, the request is not medically necessary.

Physical therapy for the right wrist 1 time a week for 6 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

Decision rationale: The request is for physical therapy to aid in pain relief. The MTUS guidelines states that manipulation is recommended for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. It is indicated for low back pain but not ankle and foot conditions, carpal tunnel syndrome, forearm/wrist/hand pain, or knee pain. The use of active treatment modalities instead of passive treatments is associated with substantially better clinical outcomes. (Fritz, 2007) Active treatments also allow for fading of treatment frequency along with active self-directed home PT, so that less visits would be required in uncomplicated cases. The guidelines state the following: Low back: Recommended as an option. Therapeutic

care: Trial of 6 visits over weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. Elective/maintenance care: Not medically necessary. Recurrences/flare-ups: Need to reevaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months. Ankle & Foot: Not recommended. Carpal tunnel syndrome: Not recommended. Forearm, Wrist, & Hand: Not recommended. Knee: Not recommended. In this case, the patient does not qualify for physical therapy as indicated above and would benefit most from at home active therapy. As such, the request is not medically necessary.

Tramadol 50mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

Decision rationale: Tramadol is a pain medication in the category of a centrally acting analgesic. They exhibit opioid activity and a mechanism of action that inhibits the reuptake of serotonin and norepinephrine. Centrally acting drugs are reported to be effective in managing neuropathic type pain although it is not recommended as first line therapy. The side effect profile is similar to opioids. For chronic back pain, it appears to be efficacious for short term pain relief, but long term (>16 weeks) results are limited. It also did not appear to improve function. The use of tramadol for osteoarthritis is indicated for short term use only (<3 months) with poor long-term benefit. In this case, the patient does not meet the qualifying criteria. This is secondary to the duration of use, with this medication being indicated on a short-term basis only. As such, the request is not medically necessary.

Theramine #90: 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 (updated 07/15/15) Theramine.

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

Decision rationale: The request is for the use of Theramine. The Official Disability Guidelines state the following regarding this topic: Not recommended for the treatment of chronic pain. Theramine is a medical food that contains 5-hydroxytryptophan 95%, choline bitartrate, L-arginine, histidine, L-glutamine, L-serine, gamma-aminobutyric acid (GABA), whey protein concentrates, grape seed extract 85%, cinnamon, and cocoa (theobromine 6%). It is intended for use in the management of pain syndromes that include acute pain, chronic pain, fibromyalgia, neuropathic pain, and inflammatory pain. The proposed mechanism of action is that it increases the production of serotonin, nitric oxide, histamine, and gamma-aminobutyric acid by providing these precursors. (Micromedex, 2015) See Medical food. Under this entry discussions of the various components of this product are given. The entries for 5-hydroxytryptophan, choline bitartrate, L-arginine, histidine, L-glutamine, L-serine and GABA are given and all indicate there is no role for these supplements as treatment for chronic pain. In this case, the use of this medication is not supported by the guidelines. This is secondary to poor clinical evidence regarding efficacy in chronic pain. As such, the request is not medically necessary.

