

<b>Case Number:</b>	CM15-0020689		
<b>Date Assigned:</b>	04/15/2015	<b>Date of Injury:</b>	10/05/2000
<b>Decision Date:</b>	05/07/2015	<b>UR Denial Date:</b>	01/07/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/04/2015

### 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 64 year old female who sustained an industrial injury 10/5/2000. Her diagnoses, and/or impressions, include: traumatic arthritis of the hip with failed total hip arthroplasty (HCC) and need for hip revision; lumbar sprain/strain and radiculopathy; status-post lumbar fusion; sprain/strain sacroiliac ligament; osteoarthritis of the knee; chronic pain syndrome; morbid obesity - awaiting weight loss surgery; asthmatic bronchitis with pneumonia; and methicillin resistant staph aureus - culture positive. No current magnetic resonance imaging studies are noted. X-rays of the right knee, for pain, were noted to have been done on 7/16/2014. Her treatments have included: surgery; home exercises; the use of a cane; and medication management. The progress notes of 12/16/2014, noted complaints of lower back pain, increased by 50%, since her previous visit. The pain was described as intermittent, severe and otherwise without change. The physician's requests for treatments included Butrans patches, Neurontin, and physical therapy for the lumbar spine.

### 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, quantity: 12 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 Therapy, pages 98-99.

**Decision rationale:** Physical therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. However, there is no clear measurable evidence of progress with the PT treatment already rendered including milestones of increased ROM, strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints, clinical findings, and functional status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. The Chronic Pain Guidelines allow for 9-10 visits of physical therapy with fading of treatment to an independent self-directed home program. It appears the employee has received significant therapy sessions without demonstrated evidence of functional improvement to allow for additional therapy treatments. There is no report of acute flare-up, new injuries, or change in symptom or clinical findings to support for formal PT in a patient that has been instructed on a home exercise program for this chronic injury of October 2000. Submitted reports have not adequately demonstrated the indication to support further physical therapy when prior treatment rendered has not resulted in any functional benefit. The Physical therapy for the lumbar spine 2 times a week for 6 weeks, quantity: 12 sessions is not medically necessary and appropriate.

**Butrans Patch 10mcg #2:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Buprenorphine HCL, pages 26-27.

**Decision rationale:** Submitted reports have not demonstrated the indication or medical necessity for this medication request. Per MTUS Chronic Pain, BuTrans or Buprenorphine is a scheduled III controlled substance recommended for treatment of opiate addiction or opiate agonist dependence. Request has been reviewed previously and non-certified for rationale of lack of pain contract, indication, and documentation of opioid addiction. Buprenorphine has one of the most high profile side effects of a scheduled III medication. Per the Guidelines, opioid use in the setting of chronic, non-malignant, or neuropathic pain is controversial and use should be reserved for those with improved attributable functional outcomes. This is not apparent here as this patient reports no change in pain relief, no functional improvement in daily activities, and has not decreased in medical utilization or self-independence continuing to treat for chronic pain symptoms. There is also no notation of any functional improvement while on the patch nor is there any recent urine drug screening results in accordance to pain contract needed in this case. Without sufficient monitoring of narcotic safety, efficacy, and compliance for this individual along with no weaning process attempted for this chronic injury. Medical necessity for continued treatment has not been established for Buprenorphine. The Butrans Patch 10mcg #2 is not medically necessary and appropriate.

**Neurontin 800mg, #45:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy Drugs (AEDs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drugs/Gabapentin, pages 18-19.

**Decision rationale:** Although Neurontin (Gabapentin) has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain; however, submitted reports have not adequately demonstrated the specific symptom relief or functional benefit from treatment already rendered for this chronic injury. Medical reports have not demonstrated specific change, progression of neurological deficits or neuropathic pain with functional improvement from treatment of this chronic injury. Previous treatment with Neurontin has not resulted in any functional benefit and medical necessity has not been established. The Neurontin 800mg, #45 is not medically necessary and appropriate.