

Case Number:	CM13-0021733		
Date Assigned:	11/13/2013	Date of Injury:	11/23/2010
Decision Date:	02/05/2014	UR Denial Date:	08/27/2013
Priority:	Standard	Application Received:	09/09/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Internal Medicine, has a subspecialty in Pulmonary Diseases, and is licensed to practice in California. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 41-year-old female who reported an injury on 03/14/2013. The patient is diagnosed with low back pain. The patient was seen by [REDACTED] on 07/01/2013. Physical examination revealed normal gait, normal range of motion, 5/5 motor strength in the bilateral lower extremities, 2+ deep tendon reflexes, and intact sensation. Treatment recommendations included 12 sessions of physical therapy and continuation of current medication

IMR ISSUES, DECISIONS AND RATIONALES

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

Decision for Physical Therapy x12 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

Decision rationale: California MTUS Guidelines state active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Guidelines allow for a fading of treatment of treatment frequency, plus active, self-directed home physical medicine. Treatment for myalgia and myositis unspecified includes 9 to 10 visits over 8 weeks. Treatment

for radiculitis or neuritis includes 8 to 10 visits over 4 weeks. The current request for physical therapy for the lumbar spine x12 sessions exceeds guideline recommendations. Furthermore, there was no evidence of a significant musculoskeletal or neurological deficit upon physical examination that would warrant the need for skilled physical medicine treatment. The medical necessity has not been established. Therefore, the request is non-certified

Ultram ER: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Baseline pain and functional assessments should be made. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. As per the clinical notes submitted, there is no evidence of a failure to respond to non-opioid analgesics prior to the initiation of an opioid medication. The total duration of use was not specified in the documentation provided for review. The patient's physical examination does not reveal significant musculoskeletal or neurological deficit that would require ongoing opioid management. Medical necessity for the requested medication has not been established. Therefore, the request is non-certified

Voltaren XR 100mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-72.

Decision rationale: California MTUS Guidelines state NSAIDs are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain. There is no evidence to recommend 1 drug in this class over another based on efficacy. As per the clinical notes submitted, the patient does not maintain a diagnosis of osteoarthritis. Furthermore, guidelines do not recommend chronic use of NSAID medication. The medical necessity for the requested medication has not been established. Therefore, the request is non-certified.

Home Ortho Stimulator Unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 117-121.

Decision rationale: Ortho-stimulator units combine high volt pulse current stimulation and neuromuscular electrical stimulation, as well as interferential stimulation. Interferential current stimulation is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise, medications, and limited evidence of improvement on those recommended treatments alone. Neuromuscular electrical stimulation is not recommended. As per the clinical notes submitted, there is no documentation of failure to respond to first-line treatment including exercise, physical therapy, or medication. There is also no evidence of pain that is ineffectively controlled due to diminished effectiveness of medication or side effects. There was no documentation of a treatment plan with specific short-term and long-term goals of treatment with the ortho stimulator unit. The medical necessity for the requested service has not been established. Therefore, the request is non-certified.