

Case Number:	CM13-0025562		
Date Assigned:	11/20/2013	Date of Injury:	03/22/2002
Decision Date:	02/06/2014	UR Denial Date:	08/28/2013
Priority:	Standard	Application Received:	09/17/2013

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 Family Medicine and is licensed to practice in Texas. 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 clinical documentation does not meet the guideline recommendations. The clinical documentation submitted for review states the patient complained of pain to the low back with radiation to the lower bilateral legs and decreased range of motion. The patient was reported to have had extensive amounts of directed physiotherapy and home exercise over the years. CA MTUS stated physical medicine can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation, and swelling, and to improve the rate of healing soft tissue injuries. 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. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. However, no objective clinical documentation was submitted to show the patient's initial or interim findings with physical therapy or the home exercise program. As such, the request is non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Aqua Physical Therapy x 8 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aquatherapy Page(s): 22.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 58, 59.

Decision rationale: The clinical documentation does not meet the guideline recommendations. The clinical documentation submitted for review states the patient complained of pain to the low back with radiation to the lower bilateral legs and decreased range of motion. The patient was reported to have had extensive amounts of directed physiotherapy and home exercise over the years. CA MTUS stated physical medicine can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation, and swelling, and to improve the rate of healing soft tissue injuries. 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. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. However, no objective clinical documentation was submitted to show the patient's initial or interim findings with physical therapy or the home exercise program. As such, the request is non-certified.

Zofran ODT 8mg, # 10 dispensed on 8/12/13: 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), Treatment Index, 11th Edition (web), 2013, Pain, Workers compensation drug formulary

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Ondansetron (Zofran®).

Decision rationale: CA MTUS/ACOEM does not address this request. The clinical documentation does not meet the guideline recommendations. The clinical documentation submitted for review states the patient had complaints of pain and was using Norco, Anaprox DS, Clonidine, Zofran, Xanax, Prozac, Ambien, Lisinopril, Prilosec, Percocet, and Lortab. The patient was also diagnosed with medication induced gastritis. Official Disability Guidelines does not recommended Zofran for nausea and vomiting secondary to chronic opioid use. The clinical documentation submitted for review does not indicate the patient has had complaints nausea or vomiting. As such, the request is non-certified.