

Case Number:	CM14-0013806		
Date Assigned:	09/16/2014	Date of Injury:	12/05/2010
Decision Date:	10/15/2014	UR Denial Date:	01/21/2014
Priority:	Standard	Application Received:	02/03/2014

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. The expert reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Management 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 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/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:

According to the records made available for review, this is a 51-year-old female with a 12/5/10 date of injury and status post bowel resection and abdominal hernia repair on 1/13/11 and 1/30/11. At the time (3/18/11) of request for authorization for Physical therapy requested 2/15/11 and Retrospective request for Gabadone PM #60 DOS: 3/18/11, there is documentation of subjective (abdominal/hernia pain, mid back pain, low back pain with radicular pain, bilateral hip pain, difficulty sleeping, and anxiety/depression) and objective (decreased lumbar range of motion, decreased ankle reflexes, tightness and spasm of the lumbar paraspinal muscles, hypoesthesia at the L5 and S1 dermatomes, lumbar facet joint tenderness, positive cough impulse test of the umbilical area) findings, current diagnoses (rule out herniated lumbar disc and radiculitis, bilateral hip trochanteric bursitis, status post umbilical hernia repair x2, anxiety/depression, and intermittent insomnia), and treatment to date (umbilical hernia repair). Medical report identifies a request for Gabadone for sleep disorder and physical therapy to the low back 2x/week for 6 weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy requested 2/15/11: 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) Preface

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, Physical therapy Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines support a brief course of physical medicine for patients with chronic pain not to exceed 10 visits over 4-8 weeks with allowance for fading of treatment frequency, with transition to an active self-directed program of independent home physical medicine/therapeutic exercise. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG recommends a limited course of physical therapy for patients with a diagnosis of lumbar radiculitis not to exceed 10 visits over 8 weeks. ODG also notes patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy) and when treatment requests exceeds guideline recommendations, the physician must provide a statement of exceptional factors to justify going outside of guideline parameters. Within the medical information available for review, there is documentation of diagnoses of rule out herniated lumbar disc and radiculitis, bilateral hip trochanteric bursitis, status post umbilical hernia repair x2, anxiety/depression, and intermittent insomnia. In addition, there is documentation of a request for initial physical therapy to the low back 2x/week for 6 weeks, functional deficits, and functional goals. However, the requested number of sessions (12) exceeds guidelines (for an initial trial). Therefore, based on guidelines and a review of the evidence, the request for Physical therapy requested 2/15/11 is not medically necessary.

Retrospective request for Gabadone PM #60 DOS:3/18/11: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, page 136

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

Decision rationale: MTUS does not address the issue. ODG identifies that Gabadone is a medical food consisting of a proprietary blend of Choline Bitartrate, Glutamic Acid, 5-Hydroxytryptophan and GABA, intended to meet the nutritional requirements for inducing sleep, promoting restorative sleep, and reducing snoring in patients who are experiencing anxiety related to sleep disorders. In addition, ODG identifies that Gabadone is not recommended. Therefore, based on guidelines and a review of the evidence, the request for Retrospective request for Gabadone PM #60 DOS: 3/18/11 is not medically necessary.