

Case Number:	CM14-0121125		
Date Assigned:	08/06/2014	Date of Injury:	03/06/2014
Decision Date:	10/02/2014	UR Denial Date:	07/17/2014
Priority:	Standard	Application Received:	07/31/2014

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 Occupational Medicine 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:

The injured worker is a 52-year-old female who has submitted a claim for lumbosacral spondylosis without myelopathy associated with an industrial injury date of 03/06/2014. Medical records from 03/14/2014 to 07/07/2014 were reviewed and showed that patient complained of low back pain graded 3/10. Physical examination revealed no tenderness, decreased lumbar ROM, weakness of left hip flexors and right knee flexors, and negative SLR tests bilaterally. MRI of the lumbar spine dated 03/14/2014 revealed L2-3, L4-5, and L5-S1 degenerative disc disease and L4-5 and L5-S1 annular tears. Treatment to date has included at least 12 visits of physical therapy, chiropractic care, Tramadol HCl 150mg (prescribed 05/12/2014), and HEP. Of note, there was no documentation of functional outcome concerning previous physical therapy visits and opioids use. Utilization review dated 07/17/2014 denied the request for physical therapy, twice a week for three weeks for the lumbar spine because the patient has already completed 12 sessions of physical therapy without significant improvement. Utilization review dated 07/17/2014 denied the request for Styrofoam roller because Styrofoam roller is not medically necessary for either at-home stretching or core exercises. Utilization review dated 07/17/2014 denied the request for Ultram 150mg #30 because opioids were not medically necessary for a patient who has a 4 month-old injury.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy twice a week three weeks to the lumbar spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines- Low back

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

Decision rationale: According to pages 98-99 of the MTUS Chronic Pain Medical Treatment Guidelines, active therapy is recommended 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. Physical medicine guidelines allow for fading of treatment frequency from up to 3 visits per week to 1 or less plus active self-directed home physical medicine. The Official Disability Guidelines (ODG) recommends 10 visits of physical therapy over 8 weeks for patients with intervertebral disc disorder without myelopathy. In this case, the patient has already completed 12 visits of physical therapy which exceeded guidelines recommendation. Moreover, there was no documentation of functional outcome concerning previous physical therapy visits. It is unclear as to why the patient cannot self-transition into HEP. Therefore, the request for Physical therapy twice a week for three weeks for the lumbar spine is not medically necessary.

Styrofoam roller: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, Durable Medical Equipment

Decision rationale: The MTUS does not address this topic. According to the Official Disability Guidelines, Durable Medical Equipment (DME) is recommended generally if there is a medical need and if the device meets the Medicare's definition of DME as: can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury, and is appropriate for use in a patient's home. In this case, the patient had low back pain complaint which prompted the request for a styrofoam roller. However, a styrofoam roller does not fit the description of DME as it is not primarily used to serve a medical purpose, its durability is questionable, and it is still useful even in the absence of injury. Therefore, the request for a styrofoam roller is not medically necessary.

Ultram 150mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Page(s): 78.

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines state that ongoing opioid treatment should include monitoring of analgesia, activities of daily living, adverse side effects, and aberrant drug-taking behaviors; these outcomes over time should affect the therapeutic decisions for continuation. There was no documentation of pain relief, functional improvement, and recent urine toxicology review, which are required to support continued use of opiates. In this case, the patient was prescribed opioids (Tramadol HCl 150mg) since 05/12/2014. There was no documentation of analgesia or functional improvement to warrant continuation of opiates use. The medical necessity for Ultram cannot be established due to insufficient information. Therefore, the request for Ultram 150mg #30 is not medically necessary.