

Case Number:	CM14-0135922		
Date Assigned:	09/03/2014	Date of Injury:	05/12/2006
Decision Date:	10/03/2014	UR Denial Date:	07/23/2014
Priority:	Standard	Application Received:	08/25/2014

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 Orthopedics and is licensed to practice in Arizona. 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:

This 45-year-old female licensed vocational nurse sustained a back-related injury on 5/12/2006 when she experienced a sudden onset of pain when she reached for a shampoo bottle while bathing a patient in an awkward position leading to immediate complaints of low back pain, neck pain and extremity discomfort. Back pain varies from 5/10 to 10/10 [visual analog scale (VAS) scale]. At the time of the accident she was employed full-time. In addition she also sustained pathological vertebral fractures [T9 & T10] and is also addicted to opioids. She apparently also has the following additional problems:- Fibromyalgia- Hypothyroid disease- Migraines- Recently diagnosed as type II Diabetes Mellitus- Obesity [BMI=40]-Neurogenic bladder and - Tremors [no detail]Current 'working diagnosis' given as lumbo-sacral spondylosis, cervical disc degeneration, primary [localized] osteoarthrotic, pain disorder associated with both psychological and a general medical condition [307.89] and major depressive disorder [296.32] [recurrent and severe]. Her symptoms include: o Complains of low back and thoracic spine pain of 8 years duration.o Continual pain in cervical spine, head & bilateral upper extremities, left hand, left fingers, right hand, wrist and fingers rated as 8/10.o Migraine attacks [2-7 attacks / week.o She is using a regular wheelchair with difficulty.o Depression.o Sleep problems.o Family-related problems.o Involuntary loss of bowel and bladder control [4/3/2014].Physical examination revealed no signs of upper or lower extremity radiculopathy.Treatment rendered/prescribed since day of injury:- Seen and admitted via emergency room on 7/12/2014 for pain control, diarrhea & dehydration. Reason for relapse was that she could not afford her medications.- Drugso Decadron injections.o Soma [for spasms secondary to untreated compression #'s].o Klonopin [for sleep disorder].o Duragesic pad [long acting 75 cg/hour for pain].o Dilaudid [hydromorphone] 3 / day. Cymbalta < 120 mg/day.o Lyrica <600 mg/day.- Physical therapyo She was prescribed PT while she was admitted [7/12/2014].oHer physician

prescribed 12 PT visits on 6/27/2014. oPatient underwent physiotherapy previously for her back-related symptoms but no documentation regarding frequency or outcome as regards objective functional improvement was available to me. - Individual cognitive-behavioral psychotherapy [had 4 sessions and patient noted some improvement.- Prescribed an intra thecal pain pump for chronic pain.- Prescribed kyphoplasty for T10 vertebral fracture [kyphoplasty of T 9 had >50 % good response in November 2012.- Home health aide suggested.- Prescribed power wheelchair [5/29/2014].- Suggested dental consult [5/29/2014] for caries.- Weight loss program to include aqua therapy.- Urologist consults [3/20/2014]. Diagnosed neurogenic bladder caused by initial injury!- Surgical history was not available.Diagnostic studies consisted of:- Plain X-rays [report not available].- MRI-study [Area & report not available].- Blood work-up [during admission for pain control].- Urology work-up tests consisting of [done during March 2014]:o Uroflowmetry.o Bladder scan.o Measurement of post-void residual volume.oCystoscopy examination and o Urodynamic study.Diagnosis was initially documented as lumbo-sacral spondylosis[7213].Recommendations: 12 physical therapy (PT) visits for thoracic and lumbar spine problem. Work status designated as TPD [Temporary Partial Disability], TTD [Temporary Total Disability], P & S with no limitations/restrictions. UR [Utilization Review] request: 12 PT visits for thoracic and lumbar spine [7/21/2014-9/4/2014].UR date of denial was on 7/23/2014. UR decision was that this treatment did not adhere to evidence-based treatment.

IMR ISSUES, DECISIONS AND RATIONALES

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

Twelve (12) Physical Therapy visits for the thoracic and lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Lumbar spine, Physiotherapy

Decision rationale: This patient presents virtually all the criteria of chronic non-specific back pain and is, in my opinion, beyond conventional treatment for back pain but I will answer only the question asked and not dwell on other treatment options.Chronic Pain MTUS guideline states 12 physical medicine visits [that includes self-directed home exercise instruction] to be adequate as initial approach. Documentation regarding the detail and clinical outcome of this patient's initial physical therapy treatment was not available. We therefore do not know the clinical outcome of previous physiotherapy treatment and I cannot support 12 more PT sessions. Reassessment should have occurred after 6 visits, with continuation based on patient compliance, objective functional improvement, and symptom reduction. Documentation of these criteria was not available. The only need for further physical therapy treatment would be to emphasize the home exercise program or to address her general ambulation issues, and would not require more than 2 additional visits to reinforce the home exercise program regarding her thoracic and lumbar spine. The patient should be able to continue to follow a well-structured exercise program at home.ACOEM Guidelines Plus (California version) states that if the patient failed prior exercise therapy, which is not known, we can consider 6 additional exercise visits (only 6), or consider

an interdisciplinary approach. Physiotherapy approach can be passive therapy or active therapy [preferred] but the use of active treatment modalities (e.g., exercise, education, and activity modification) instead of passive treatments is associated with substantially better clinical outcomes. For patients with mild symptoms and minimal disability, treatment should consist of a therapy evaluation to instruct the patient in a home-based exercise program, with 1 to 2 follow-up visits. If the patient failed prior exercise therapy, MTUS suggest 6 additional exercise visits, or consideration of an interdisciplinary approach [functional restoration program]. ACOEM states that "Evidence-based medicine focuses on the need for health care providers to rely on a critical appraisal of available scientific evidence rather than clinical opinion or anecdotal reports in reaching decisions regarding diagnosis, treatment, causation, and other aspects of health care decision making." The wave of the future is evidence -based medicine (EBM) compared to experience-based medicine of the past. (Corbin 2006). Official Disability Guide: Physical medicine treatment should be an option when there is evidence of a musculoskeletal or neurologic condition that is associated with functional limitations; the functional limitations are likely to respond to skilled physical medicine treatment (e.g., fusion of an ankle would result in loss of ROM (Range of Motion) but this loss would not respond to Physical Therapy, though there may be PT needs for gait training, etc.); care is active and includes a home exercise program & the patient is compliant with care and makes significant functional gains with treatment. Therefore, the request of twelve (12) Physical Therapy visits for the thoracic and lumbar spine is not medically necessary and appropriate.