

Case Number:	CM14-0172540		
Date Assigned:	10/23/2014	Date of Injury:	11/03/2006
Decision Date:	11/25/2014	UR Denial Date:	09/29/2014
Priority:	Standard	Application Received:	10/18/2014

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 Physical Medicine and Rehabilitation 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:

This 61 year-old injured worker sustained an injury on 11/3/06 while employed by [REDACTED]. Request(s) under consideration include 8 sessions of physical therapy, Acupuncture (unknown sessions), and 1 Demo kit and traction unit. Diagnoses include lumbar region sprain. Conservative care has included medications, therapy, acupuncture, and modified activities/rest. Review indicated previous certification for physical therapy of 12 sessions on 7/23/14 and 6 acupuncture visits on 5/9/13. Reports of 4/15/13 and 8/22/13 from the provider noted the injured worker with improvement from acupuncture treatments, there was no specific documented functional improvement. Report of 6/12/14 noted the injured worker with severe back and knee pain, unable to work. Exam showed positive diffuse generalized pain on palpation of lumbar spine. Report of 9/8/14 from the provider noted the injured worker with ongoing chronic complaints to multiple body regions with asthma symptoms. Exam showed diffuse tenderness to palpation; decreased range of motion in all planes to multiple areas with positive provocative testing of sacroiliac stress, impingement sign, cross arm sign, Phalen's test, and McMurray's test; diffuse decreased sensation at C5-7 and L4-S1 dermatomes on left with intact DTRs and motor strength throughout. The request(s) for 8 sessions of physical therapy, Acupuncture (unknown sessions), and 1 Demo kit and traction unit were non-certified on 9/29/14 citing guidelines criteria and lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

8 Sessions of Physical Therapy: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines, Physical Therapy Guidelines; Low Back-Lumbar & Thoracic (Acute & Chronic), Knee & Leg (Acute & Chronic)

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

Decision rationale: Physical therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. However, there is no clear measurable evidence of progress with the physical therapy treatment already rendered including milestones of increased range of motion, strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints, clinical findings, and work status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. The Chronic Pain Guidelines allow for 9-10 visits of physical therapy with fading of treatment to an independent self-directed home program. It appears the employee has received at least 12 recent therapy sessions certified in July 2014 without demonstrated evidence of functional improvement to allow for additional therapy treatments. There is no report of acute flare-up, new injuries, or change in symptom or clinical findings to support for formal physical therapy in a patient that has been instructed on a home exercise program for this chronic injury. Submitted reports have not adequately demonstrated the indication to support further physical therapy when prior treatment rendered has not resulted in any functional benefit. The 8 sessions of physical therapy is not medically necessary.

Acupuncture: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Acupuncture Medical Treatment Guidelines Page(s): 8-9.

Decision rationale: MTUS, Acupuncture Guidelines recommend initial trial of conjunctive acupuncture visit of 3 to 6 treatment with further consideration upon evidence of objective functional improvement. Submitted reports have not demonstrated the medical indication to support continued acupuncture. Although the patient reported improvement, medical reports noted unchanged pain symptoms and clinical findings despite extensive conservative care to include acupuncture for this chronic injury of 2006. The patient remains functionally unchanged from acupuncture treatment visits already rendered. There is no demonstrated functional improvement derived from treatment completed in terms of increased ADLs, function, or decreased medical utilization and VAS level. The Acupuncture (unknown sessions) is not medically necessary.

Demo Kit and Traction Unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 173-174, 146-147, 300.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Traction, page 496

Decision rationale: There are no MRI findings showing clear neural foraminal stenosis or nerve impingement and clinical findings has no correlating dermatomal or myotomal neurological deficits identified. Submitted reports have not demonstrated the indication or medical necessity for this traction unit without documented functional improvement from DME trial prior home use. Regarding the Low Back, traction has not been proved effective for lasting relief in treating low back pain. Because evidence is insufficient to support using vertebral axial decompression for treating low back injuries, it is not recommended. Traction for low back condition is not recommended, but may be a noninvasive conservative option, if used as an adjunct to a program of evidence-based conservative care to achieve functional restoration not demonstrated here. As a sole treatment, traction has not been proved effective for lasting relief in the treatment of low back pain. Submitted reports have not demonstrated the indication or medical necessity for these traction purchases. The request for a Demo Kit and Traction Unit is not medically necessary.