

Case Number:	CM14-0044488		
Date Assigned:	07/02/2014	Date of Injury:	06/24/2008
Decision Date:	08/27/2014	UR Denial Date:	04/10/2014
Priority:	Standard	Application Received:	04/11/2014

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 & Rehab and is licensed to practice in Texas and Ohio. 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 55-year-old male who reported an injury on 06/24/2008 due to a lifting injury. The injured worker reportedly sustained an injury to his cervical spine and lumbar spine. The injured worker's treatment history included failed multilevel cervical fusion due to nonunion, physical therapy, epidural steroid injections, medications, lumbar facet injections, and cognitive behavioral therapy. A cognitive behavioral therapy note dated 02/03/2014 noted that the injured worker was making poor progress and had a poor outlook on functional restoration. The injured worker was evaluated on 02/27/2014. Physical findings included decreased range of motion of the cervical spine secondary to pain and significant giveway weakness and multiple muscle groups. The injured worker's diagnoses included disc degeneration of the lumbar spine and cervical spine and cervical radiculopathy. It was noted that the injured worker was not a good surgical candidate and would possibly be a candidate for an intrathecal pain pump. A request was made for evaluation for an intra-thecal pain pump and physical therapy 2 times a week for 4 weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy Lumbar Spine 2 x 4: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 83, Chronic Pain Treatment Guidelines Physical Therapy Page(s): 103.

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

Decision rationale: The requested decision for physical therapy for the lumbar spine 2 times a week for 4 weeks is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends injured workers be transitioned into a home exercise program to maintain improvement levels obtained during skilled physical therapy. The clinical documentation submitted for review does not clearly indicate that the injured worker is currently participating in a home exercise program. Therefore, 1 to 2 visits to re-establish a home exercise program would be indicated in this clinical situation. However, 8 additional visits would be considered excessive. As such, the requested physical therapy for the lumbar spine 2 times a week for 4 weeks is not medically necessary or appropriate.

Evaluation for an intrathecal pain pump: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Indications for Implantable drug-delivery systems.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Psychological evaluations, IDDS & SCS (intrathecal drug delivery systems & spinal cord stimulators) Page(s): page(s) 101.

Decision rationale: Evaluation for an intrathecal pain pump is not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends a psychological evaluation to determine the appropriateness of the requested medical intervention prior to placement of an intrathecal pain pump. The request as it is submitted does not specifically identify what type of evaluation is being requested. Therefore, the appropriateness of the request itself cannot be determined. Additionally, as the injured worker has not had a psychological evaluation to support that they are an appropriate candidate for an intrathecal pain, further evaluation for this treatment modality would not be indicated. As such, the requested evaluation for an intrathecal pain pump is not medically necessary or appropriate.