

Case Number:	CM14-0056490		
Date Assigned:	07/09/2014	Date of Injury:	04/12/2012
Decision Date:	09/11/2014	UR Denial Date:	04/17/2014
Priority:	Standard	Application Received:	04/26/2014

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 patient is a 40-year-old male who has submitted a claim for lumbosacral joint/ligament sprain/strain, lumbosacral/thoracic neuritis or radiculitis, myofascial pain, lumbar radiculopathy (left sided) L5, and iliotibial syndrome associated with an industrial injury date of April 12, 2012. Medical records from 2013-2014 were reviewed. The patient complained of constant low back pain, rated 4/10 in severity. The pain radiates to the left lower extremity with associated numbness and tingling down to the medial calf. Physical examination showed tenderness of the lumbar paraspinal muscles. Decreased range of motion of the lumbar spine was also noted. There was reduced sensation of the left lower extremity, particularly at the left L4-L5 distribution. MRI of the lumbar spine, dated January 24, 2014, revealed no disc herniation, slight annular bulging at L4-L5 level with short pedicles and mild arthropathy causing minimal caudal foraminal narrowing, mild L2-L3 disc desiccation and diffuse annular bulge less than 3 mm, and no central canal stenosis. Treatment to date has included medications, physical therapy, chiropractic treatment, acupuncture, TENS, home exercise program, and activity modification. Utilization review, dated April 17, 2014, denied the request for physical therapy qty: 16.00 because there was no indication for additional physical therapy in excess of the guidelines; and denied the request for medication (unspecified) qty: 1.00 because there was no documentation of current medications, doses, actual frequency of use, symptomatic and functional benefit.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY QTY 16: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation 2009 ACOEM GUIDELINES (2ND EDITION)OFFICIAL DISABILITY GUIDELINES- PHYSICAL THERAPY GUIDELINES.

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 Chapter, Physical Therapy.

Decision rationale: As stated on pages 98-99 of the CA MTUS Chronic Pain Medical Treatment Guidelines, a time-limited treatment plan with clearly defined functional goals, frequent assessment and modification of the treatment plan based upon the patient's progress in meeting those goals, and monitoring from the treating physician regarding progress and continued benefit of treatment is paramount. In addition, 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. Official Disability Guidelines recommend 10 visits over 8 weeks for intervertebral disc disorders with or without myelopathy and for lumbar sprain/strain. In this case, the patient has persistent low back pain. The rationale for the request was for iliotibial band and lumbar core strengthening. Patient was certified a total of 12 physical therapy visits since April 2014. It is not known whether the patient underwent these sessions or not. There was no documentation of the previous physical therapy visits and there was no description regarding objective benefits derived from these sessions or a treatment plan with defined functional gains and goals. Furthermore, recent progress reports did not document any acute exacerbation or flare-up of symptoms. Patient is also expected to be well-versed in a self-directed home exercise program by now. Furthermore, the present request would exceed the number of physical therapy visits for the lumbar spine as recommended by the guidelines. Moreover, the request failed to specify the body part to be treated. Therefore, the request for PHYSICAL THERAPY QTY 16 is not medically necessary.

MEIDCATION UNSPECIFIED QTY 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG,), Pain Section, Medications for Subacute and Chronic Pain.

Decision rationale: The CA MTUS does not specifically address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers Compensation, the Official Disability Guidelines (ODG), Pain Section was used instead. It states that relief of pain with the use of medications is generally temporary, and measures of the lasting benefit from this modality should include evaluating the effect of pain relief in relationship to improvements in function and increased activity. Before prescribing any medication for pain the following should occur: (1) determine the aim of use of the medication; (2) determine the potential benefits and adverse effects; (3) determine the patient's preference. In this case, a progress report dated June 3, 2014 states that patient's current medications include

Naproxen, Omeprazole, Cyclobenzaprine, Lidopro ointment, and Topiramate. However, the present request failed to specify the particular medication to be requested for this patient. The medical necessity has not been established due to non-specificity of the request. Therefore, the request for MEDICATION UNSPECIFIED QTY 1.00 is not medically necessary.