MAXIMUS Federal Services

Case Number:	CM14-0079228		
Date Assigned:	07/18/2014	Date of Injury:	01/21/2011
Decision Date:	08/25/2014	UR Denial Date:	05/19/2014
Priority:	Standard	Application Received:	05/29/2014

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 Pain Management 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:

The injured worker is 43 years old female with injury dates of 5/12/10 and 01/21/11 as well as a continous trauma to the lumbar spine. She is diagnosed with Lumbar spine enthesopathy, lumbar spine disc extrusion (L5-S1, status post microdiscectomy), Lumbar spine disc bulges (L4-5, L5-S1), and right lower extremity radiculitis. The injured worker is also noted to have depression, anxiety and difficulty sleeping. Her medications include Meloxicam, Ibuprofin, Paroxetine hcl, Tramadol, Naproxen, and Gabapentin. She has had approximately one year of postoperative physical therapy, 2 sessions of aquatic therapy and 8 sessions of acupuncture. MRI has showed spondylotic changes of multilevels, including neuroforaminal narrowin and canal stenosis. EMG was negative for radiculopathy. On exam, she has tenderness to palpation of paralumbar spine with right sided spasm. The SLR was negative. The right Achilles reflex was absent. Strength was 5/5, but sensation was decreased to light touch at right L5 and S1 dermatoms. The plan was physical therapy 2 times a week for 4 weeks with hot pack application, therapeutic exercises, home exercise program, joint mobilization, soft tissue mobilization message therapy. Previous request for Psychologist/Psychiatrist consultation, physical therapy to treat the lumbar spine 3x4, and home exercise kit for the lumbar spine was non- certified on 5/19/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Psychologist/Psychiatrist Consultation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG(The Official Disability Guidelines) Mental Illness & Stress (updated 04/09/14) Office VisitsAmerican College of Occupational and Environmental Medicine (ACOEM) Practice Guidelines, page 127.

MAXIMUS guideline: Decision based on MTUS ACOEM.

Decision rationale: As per CA MTUS/ACOEM guidelines, the occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. In this case, the specific issue for the psychology consultation has not been addressed, as the injured worker has had psychological consultation in the past. The reason for psychiatric consultation has not been specified. The injured worker is noted to have depression, anxiety and difficulty sleeping. As such, there is no evidence of uncertainty or complexity in the diagnosis. Furthermore, there is no documentation of a detailed assessment by the treating / primary care physician to rule out correctable causes such as pain level, sleep hygiene or to attempt adjusting the medications. Therefore, the medical necessity of the requested Psychologist/Psychiatrist Consultation cannot be established at this time.

PT(Physical Therapy) Lumbar Spine 3 x 4 (12): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines Page(s): 99. Decision based on Non-MTUS Citation ODG(The Official Disability Guidelines) Low Back(updated 05/12/14) Physical Therapy (PT).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

Decision rationale: As per CA MTUS guidelines, physical medicine is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. The guidelines recommend 9-10 visits for myalgia and myositis, 8-10 visits for neuralgia, neuritis, and radiculitis, 9 visits over 8 weeks Intervertebral disc disorders without myelopathy, 10 visits over 8 weeks for Lumbar sprains and strains, 10 visits over 8 weeks for Lumbago / Backache, unspecified. CA MTUS - Physical Medicine; Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. In this case, there is no documentation of any significant improvement in the objective measurements such as pain level, range of motion, strength or function with prior treatments. There is no mention of the patient utilizing an HEP (At this juncture, this patient should be well-versed in an independently applied home exercise program, with which to address residual complaints, and maintain functional levels). There is no evidence of presentation of an acute or new injury with significant findings on examination. Furthermore, the request for physiotherapy exceeds the guidelines recommendation taking into account the prior treatments. Therefore, the request for Physical Therapy is not medically necessary and appropriate in accordance with the guidelines.

Home Exercise Kit for the Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Exercise Page(s): 46-47.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

Decision rationale: The submitted clinical information is limited, as a number of questions remain unanswered. The type and details of the home exercise kit is unknown. There is no mention of the purpose of the home exercise kit. It's not clear wheather or not the injured worker has received training and is capable of self-administering the requested device. The type of exercise program in this case is unclear. Therefore, the request for Home Exercise Kit is not medically necessary.