

Case Number:	CM14-0204621		
Date Assigned:	12/30/2014	Date of Injury:	10/08/1993
Decision Date:	02/05/2015	UR Denial Date:	10/31/2014
Priority:	Standard	Application Received:	12/08/2014

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 Internal 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 injured worker (IW) is a 57-year-old man with a date of injury of October 8, 1993. The mechanism of injury was a slip and fall. The injured worker's working diagnoses are recurrent lower back pain; medication withdrawal; anxiety, panic disorder; and autonomic dysflexia. Pursuant to a progress note dated September 8, 2014, the IW complained of low back pain. The IW also had complaints of shallow breathing; ringing in the ears; dizziness; flushing face; sweating; tingling all over the body, especially in the head; body aches; sleep disturbances; severe disorientation; confusion; head spinning; inability to eat; agitation; and sensitivity to light for 3 weeks or more due to weaning off of OxyContin and Valium. Objective documentation includes medication withdrawal, constant low back pain, shortness of breath, and severe disorientations, confusion, and autonomic dysflexia. The treating physician requested a referral for inpatient status at [REDACTED] for opiate withdrawal. Xanax 0.25mg was prescribed for anxiety. According to a progress note dated October 1, 2014, the provider indicates that the IW was admitted to [REDACTED], but he could not stay there because they could not provide any services. A progress note from [REDACTED] dated September 18, 2014 indicated the IW was admitted on September 18, 2014 and left against medical advice (AMA). The provider requests authorization for 3-phase detoxification. Phase I: Intensive care X 3 days on telemetry to include IV fluids and medications for nausea and vomiting. Phase II: Methadone 10mg to 20mg daily for 2 months with taper and outpatient behavioral therapy, physical therapy, and occupational therapy 12 to 18 sessions. Phase III: The IW is NSAIDS-off OxyContin SR, Valium, heat and ice therapy. The current request is for physical therapy 6 to 12 sessions (part of phase II of detoxification program), and behavioral therapy 6 to 12 sessions.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 6-12 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 23, 30, 61-62-98-99.

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); Pain Section, Physical Therapy.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, the request for physical therapy 6 to 12 sessions is not medically necessary. Patient should be formally assessed after his six visit clinical trial to see if the patient is moving in a positive direction, no direction or negative direction (prior to continuing with physical therapy). The Official Disability Guidelines enumerate the frequency and duration of physical therapy based on physical injuries. In this case, the injured worker's working diagnoses are recurrent low back pain; medication withdrawal; anxiety, panic disorder; and autonomic dyslexia. A progress note dated September 8, 2014 indicates the patient was having subjective complaints of shallow breathing, ringing in ears, dizziness. There is no physical examination in September 8, 2014 progress note. A request was submitted for inpatient admission to [REDACTED] for opiate withdrawal. The documentation states "advise patient to go to emergency room if these symptoms persist or increase". The documentation is unclear based on missing objective information regarding blood pressure, heart rate, respiratory rate and other physical findings supporting acute drug withdrawal. A progress note dated October 1, 2014 shows the injured worker has similar symptoms with shallow breathing, ringing in ears, dizziness and flushing with sweating. Again, there was no physical examination performed by the treating physician. The treatment plan has a request authorization for detoxification containing three phases intensive care for three days, telemetry with IV fluids and dehydration. Additionally, there was a request for occupational therapy 12 to 18 sessions. The documentation is confusing based on the treating physician's assessment of acute drug withdrawal and concurrently concerned about providing physical therapy. [REDACTED] is not an acute care hospital. The injured worker was admitted to [REDACTED] and according to the admission history and physical, the injured worker left against medical advice. The documentation does not contain any prior physical therapy documentation. The documentation does not contain evidence of physical therapy and whether there was any objective functional improvement associated with physical therapy. A six visit clinical trial with evidence of objective functional improvement is a prelude to establishing whether further or additional physical therapy is required. There is no documentation of any prior physical therapy and what areas were being treated. Consequently, after the appropriate clinical documentation with evidence of objective functional improvement as it applies to physical therapy, the request for physical therapy 6 to 12 sessions is not medically necessary.

Behavioral therapy 6-12 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 23, 30, 61-62, and 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cognitive Behavioral Therapy Page(s): 23.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines, behavioral therapy 6 to 12 sessions are not medically necessary. The guideline provide a trial of 3 to 4 psychotherapy visits over two weeks; with evidence of objective functional improvement a total of up to 6 to 10 visits over 5 to 6 weeks may be indicated. In this case, the injured worker's working diagnoses are recurrent low back pain; medication withdrawal; anxiety, panic disorder; and autonomic dyslexia. A progress note dated September 8, 2014 indicates the patient was having subjective complaints of shallow breathing, ringing in ears, dizziness. There is no physical examination in September 8, 2014 progress note. A request was submitted for inpatient admission to [REDACTED] for opiate withdrawal. The injured worker was admitted to [REDACTED] and according to the admission history and physical, the injured worker left against medical advice. The documentation states advise patient to go to emergency room if these symptoms persist or increase. The documentation is unclear based on missing objective information regarding blood pressure, heart rate, respiratory rate and other physical findings supporting acute drug withdrawal. A progress note dated October 1, 2014 shows the injured worker has similar symptoms with shallow breathing, ringing in ears, dizziness and flushing with sweating. Again, there was no physical examination performed by the treating physician the treatment plan has a request authorization for detoxification containing three phases intensive care for three days, telemetry with IV fluids and dehydration. The treating physician is requesting 6 to 12 sessions of behavioral therapy. The guidelines recommend 3 to 4 psychotherapy visits over two weeks. With evidence of objective functional improvement a total of up to 6 to 10 visits may be appropriate. Consequently, based on the treating physicians request for 6 to 12 visits (in excess of the recommended guidelines), the request for behavioral therapy 6 to 12 sessions is not medically necessary.