

Case Number:	CM15-0017188		
Date Assigned:	02/04/2015	Date of Injury:	03/16/1995
Decision Date:	04/13/2015	UR Denial Date:	01/02/2015
Priority:	Standard	Application Received:	01/28/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: California
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 68 year old male who sustained an industrial injury on 03/16/95. He reports low back pain with radiation, numbness, and tingling. Diagnoses include cervical and lumbar strain, cervical and lumbar disc disease, right de Quervain tenosynovitis, anxiety/stress, cervicogenic headaches, status post lumbar spine surgery, right laminoforaminotomy, status post bilateral carpal tunnel release and sprain/strain of the right hand long finger. Treatments to date include medications and surgeries. In a progress note dated 12/09/14 the treating provider recommends continued medications, referral to a hand specialist, complete blood work, home exercise program, and physical therapy. On 01/02/15 Utilization Review non-certified the physical therapy, citing MTUS guidelines. The blood work was also non-certified, citing non-MTUS guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 2 x wk x 4 wks lumbar spine: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Lumbar & thoracic (Acute & Chronic).

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

Decision rationale: The 1/02/15 Utilization Review letter states the physical therapy 2 times per week for 4 weeks for lumbar spine requested on the 12/09/14 medical report was denied because the reviewer did not see and deficits on examination, although the reviewer then states: In addition, there was no indication that a home exercise program cannot address the lumbar spine deficits noted. The reviewer's rationale appears unrelated to the ACOEM and ODG guidelines cited. Per Labor Code, Section 4610.5, the MTUS Chronic Pain Medical Treatment Guidelines take precedence over ODG and ACOEM guidelines. MTUS Chronic Pain Medical Treatment Guidelines, Physical Medicine section, pages 98-99 states that 8-10 session of therapy are indicated for various myalgias or neuralgias. The records provided do not state when the patient last attended PT, but do mention the lower back complaints are worsening. There is tenderness over the L4-S1 regions with palpation and decreased lumbar flexion on physical exam. The request for PT x8 sessions is in accordance with MTUS guidelines. The request for physical therapy 2 times per week for 4 weeks for lumbar spine, IS medically necessary.

Labs-Complete Blood Work: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation
<http://www.healthcarecompliance.info/cmp.htm>.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 269.

Decision rationale: The 1/02/15 Utilization Review letter states the Labs: complete blood work requested on the 12/09/14 medical report was denied because the reviewer states MTUS/ACOEM does not discuss bloodwork, and that the history and examination did not warrant bloodwork. According to the provided medical records, the patient presents with lower back radicular symptoms, as well as paresthesia in the wrists. Tinel's was positive at the wrists. Prior electrodiagnostic studies from 8/21/14 showed medial motor and sensory latencies slowed and ulnar motor conduction was slowed at the elbow. ACOEM chapter 11, Forearm, Wrist and Hand Complaints, page 269, under Special Studies and Diagnostic and Treatment considerations states: A number of patients with hand and wrist complaints will have associated disease such as diabetes, hypothyroidism, Vitamin B complex deficiency and arthritis. When history indicates, testing for these or other comorbid conditions is recommended. The patient has persistent hand and wrist complaints. MTUS/ACOEM guidelines state testing for diabetes, hypothyroidism, arthritis and Vitamin B deficiency is recommended. The request for blood labs for evaluation for the comorbid conditions above is in accordance with MTUS/ACOEM guidelines. The request for Labs: complete blood work IS medically necessary.