

Case Number:	CM15-0026318		
Date Assigned:	02/18/2015	Date of Injury:	08/03/2011
Decision Date:	05/20/2015	UR Denial Date:	01/28/2015
Priority:	Standard	Application Received:	02/12/2015

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, Arizona

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 60 year old male, who sustained an industrial injury on 8/03/2011. The diagnoses have included degeneration of lumbar or lumbosacral intervertebral disc, other and unspecified disc disorder, cervical region, and cervicgia. Treatment to date has included surgical intervention and conservative measures. On 12/02/2014, the injured worker reported chronic cervical spine pain, overall improved, low back pain, right leg pain, better with injection, left shoulder pain, and bilateral knee pain. Exam of the bilateral knees revealed positive anterior drawer bilaterally, tenderness to palpation at the joint line, and patellofemoral crepitation. Exam of the left shoulder revealed positive impingement on the right. Exam of the lumbar spine revealed spasm, positive straight leg raise bilaterally, radiculopathy at L5-S1 bilaterally, and tenderness over the lumbar paraspinal muscles. Exam of the cervical spine showed a healed incision, decreased range of motion, and tenderness over the cervicotrapezial ridge. Current medications were not noted. Physical therapy notes, with specific dates and results, were not noted. There was no Request for Authorization form submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional Physical Therapy 2 x weekly, Lumbar Spine Qty: 12: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99.

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

Decision rationale: California MTUS Guidelines state active therapy 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. Physical medicine treatment for unspecified myalgia and myositis includes 9 to 10 visits over 8 weeks. Treatment for unspecified neuralgia, neuritis, and radiculitis includes 8 to 10 visits over 4 weeks. The current request for 12 sessions of additional physical therapy would exceed guideline recommendations. There was also no documentation of the previous course of treatment with evidence of objective functional improvement to support the necessity for additional sessions. Given the above, the request is not medically necessary.

Additional Post-op Physical Therapy, 2 times weekly for Cervical Spine Qty: 12: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 91.

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

Decision rationale: California MTUS Guidelines state active therapy 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. Physical medicine treatment for unspecified myalgia and myositis includes 9 to 10 visits over 8 weeks. Treatment for unspecified neuralgia, neuritis, and radiculitis includes 8 to 10 visits over 4 weeks. The current request for 12 sessions of additional physical therapy would exceed guideline recommendations. There was also no documentation of the previous course of treatment with evidence of objective functional improvement to support the necessity for additional sessions. There is also no indication that this injured worker has undergone a recent surgical procedure for the cervical spine. Given the above, the request is not medically necessary.

Norco 10/325mg #180: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 76-80, 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects

should occur. The injured worker has continuously utilized the above medication for an unknown duration. There is no documentation of objective functional improvement. There is also no frequency listed in the request. As such, the request is not medically necessary.

Ambien 10mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain -Zolpidem (Ambien).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Insomnia Treatment.

Decision rationale: The Official Disability Guidelines recommend insomnia treatment based on etiology. Ambien is indicated for the short-term treatment of insomnia with difficulty of sleep onset for 7 to 10 days. The injured worker does not maintain a diagnosis of insomnia disorder. There is also no evidence of a failure of non-pharmacologic treatment. There is also no frequency listed in the request. As such, the request is not medically necessary.