

Case Number:	CM15-0057056		
Date Assigned:	04/02/2015	Date of Injury:	11/07/2013
Decision Date:	05/01/2015	UR Denial Date:	02/26/2015
Priority:	Standard	Application Received:	03/26/2015

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: North Carolina
 Certification(s)/Specialty: Family Practice

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 was a 35 year old male, who sustained an industrial injury, November 7, 2013. The injured worker previously received the following treatments 10 sessions physical therapy, toxicology laboratory studies, Tramadol, Ultracet, Cyclobenzaprine, Naproxen and lumbar spine MRI. The injured worker was diagnosed with thoracic spine strain, lumbar myositis, myalgia, lumbar spine sprain/strain, insomnia, thoracic and lumbosacral neuritis/radiculopathy unspecified. According to progress note of February 18, 2015, the injured workers chief complaint was lumbar and thoracic spine pain. The physical exam noted tenderness to touch of the lumbar and thoracic spine. The injured worker was having sleep issues, stress and gastrointestinal distress. The injured worker had decreased range of motion of the lumbar spine. The treatment plan included a request of physical therapy, lumbar spine rehabilitation kit purchase and urine analysis.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 2 times a week for 6 weeks (12 sessions) for T/S & L/S: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 98-99. Decision based on Non-MTUS Citation General Approaches; ACOEM Pain, Suffering, and the Restoration of Function Chapter.

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

Decision rationale: The California chronic pain medical treatment guidelines section on physical medicine states: Recommended as indicated below. Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. 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. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. (Colorado, 2002) (Airaksinen, 2006) Patient-specific hand therapy is very important in reducing swelling, decreasing pain, and improving range of motion in CRPS. (Li, 2005) The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of patients with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment. (Fritz, 2007) Physical Medicine 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. Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2): 8-10 visits over 4 weeks Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks The requested amount of physical therapy is in excess of California chronic pain medical treatment guidelines. There is no explanation why the patient would need excess physical therapy and not be transitioned to active self-directed physical medicine. In the absence of such documentation, the request is not medically necessary.

Durable Medical Equipment: L/S rehab kit- purchase: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee Chapter; Durable Medical Equipment.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, durable medical equipment.

Decision rationale: The California MTUS and the ACOEM do not specifically address the requested item. Per the Official Disability Guidelines section on durable medical equipment, DME is primarily and customarily used to serve a medical purpose and generally not useful to a person in the absence of illness or injury. DME equipment is defined as equipment that can withstand repeated use i.e. can be rented and used by successive patients, primarily serves a medical function and is appropriate for use in a patient's home. The equipment itself is not rentable or able to be used by successive patients. Therefore criteria have not been met per the ODG and the request is not medically necessary.