

Case Number:	CM14-0129092		
Date Assigned:	08/18/2014	Date of Injury:	11/26/2013
Decision Date:	10/23/2014	UR Denial Date:	08/11/2014
Priority:	Standard	Application Received:	08/13/2014

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 Occupational 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:

This 34 year old patient had a date of injury on 11/26/2013. The mechanism of injury was being rear ended with another forklift while working, causing pain in his lower back. In a progress noted dated 7/8/2014, the patient complains of pain in thoracic spine rated 8/10, pain in the lumbar spine rated 8/10, which radiates to the feet. The pain is made worse by walking, sitting, bending, and standing. On a physical exam dated 7/8/2014, there is tenderness and spasm in the lumbosacral area. There is decreased range of motion during flexion, extension, left and right rotation. The diagnostic impression shows lumbar sprain, displacement of lumbar intervertebral disc without myelopathy. Treatment to date: medication therapy, behavioral modification, physical therapy. A UR decision dated 8/11/2014 denied the request for physical therapy for lumbar back, including infrared/massage, myofascial release, iontophoresis, electro stimulation #12, stating there is no documentation of functional improvement from previous sessions and reason why this patient needs to return to supervised exercise therapy rather than continuing with fully independent home exercise program. The condition is chronic and the patient has had physical therapy in past. Dexamethasone Sodium Phosphate 4mg/ml for the thoracic back was denied, stating there was lack of documentation regarding where this injection is to be performed, what symptoms are targeted, or home this medication will be utilized.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy for the Lumbar Back, including Infrared, Massage, Myofascial Release, Iontophoresis, Electro Stimulation #12: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine:Passive therapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) pg 114

Decision rationale: CA MTUS stresses the importance of a time-limited treatment plan with clearly defined functional goals, frequent assessment and modification of the treatment plan based upon the patient's progress in meeting those goals, and monitoring from the treating physician regarding progress and continued benefit of treatment is paramount. Physical Medicine Guidelines - Allow for fading of treatment frequency. ODG recommends 10 visits over 8 weeks for lumbar sprains and strains. However, in the documentation provided, it is unclear how many previous physical therapy visits this patient has had, and the objective functional benefits were not discussed. Furthermore, it was unclear why this patient was unable to transition into a home exercise program. Therefore, the request for Physical therapy for the Lumbar Back, including Infrared, Massage, Myofascial Release, Iontophoresis, Electro Stimulation #12 was not medically necessary.

Physical therapy for the Lumbar back, including Infrared, Massage, Myofascial Release, Iontophoresis, Electro Stimulation #12: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine: Passive therapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-9-9. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) pg 114

Decision rationale: CA MTUS stresses the importance of a time-limited treatment plan with clearly defined functional goals, frequent assessment and modification of the treatment plan based upon the patient's progress in meeting those goals, and monitoring from the treating physician regarding progress and continued benefit of treatment is paramount. Physical Medicine Guidelines - Allow for fading of treatment frequency. ODG recommends 10 visits over 8 weeks for lumbar sprains and strains. However, in the documentation provided, it is unclear how many previous physical therapy visits this patient has had, and the objective functional benefits were not discussed. Furthermore, it was unclear why this patient was unable to transition into a home exercise program. Therefore, the request for Physical therapy for the Lumbar Back, including Infrared, Massage, Myofascial Release, Iontophoresis, Electro Stimulation #12 was not medically necessary.

Dexamethasone Sodium Phosphate 4mg/ml for the thoracic back: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: FDA: Dexamethasone Injection

Decision rationale: CA MTUS and ODG do not address this issue. The FDA state that Dexamthasone injection can be adjuvant therapy for an acute episode or exacerbation of osteoarthritis, epidoncyllitis, spondylitis, or dermatitis. However, in the documentation provided, there was no clear objective functional goal discussed from this injection . Furthermore, there was no sight of injection described, and it was unclear what symptoms are being targeted. Therefore, the request for Dexamethasone Sodium Phosphate 4mg/ml for the thoracic back was not medically necessary.