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| Case Number: | CM14-0144523 | | |
| Date Assigned: | 09/12/2014 | Date of Injury: | 06/20/2011 |
| Decision Date: | 10/14/2014 | UR Denial Date: | 09/02/2014 |
| Priority: | Standard | Application Received: | 09/05/2014 |

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 Anesthesiology, has a subspecialty in Pain Management, 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:

According to the records made available for review, this is a 52-year-old male with a 6/20/11 date of injury. At the time (7/31/14) of request for authorization for physical therapy once a week for six weeks, DME to facilitate functional capacity, shockwave therapy L/S, and ortho consult, there is documentation of subjective (low back pain with spasms and weakness) and objective (decreased lumbar range of motion with pain and tenderness over the lumbar spine) findings, current diagnoses (lumbar disc syndrome and myofascitis), and treatment to date (medications and previous physical therapy). The number of previous physical therapy sessions cannot be determined. Regarding physical therapy, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services as a result of physical therapy provided to date. Regarding DME, there is no documentation of which specific DME is being requested as well as a diagnosis/condition (with subjective/objective findings) for which the requested DME is indicated. Regarding ortho consult, there is no documentation that consultation is indicated to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy once a week for six weeks: 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 physical medicine Page(s): 98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Physical therapy (PT) Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines support a brief course of physical medicine for patients with chronic pain not to exceed 10 visits over 4-8 weeks with allowance for fading of treatment frequency, with transition to an active self-directed program of independent home physical medicine/therapeutic exercise. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG recommends a limited course of physical therapy for patients with a diagnosis of spinal stenosis not to exceed 10 visits over 8 weeks. ODG also notes patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy) and when treatment requests exceeds guideline recommendations, the physician must provide a statement of exceptional factors to justify going outside of guideline parameters. Within the medical information available for review, there is documentation of diagnoses of lumbar disc syndrome and myofascitis. In addition, there is documentation of previous physical therapy treatments. Furthermore, given documentation of subjective (low back pain with spasms and weakness) and objective (decreased lumbar range of motion with pain and tenderness over the lumbar spine) findings, there is documentation of functional deficits and functional goals. However, there is no documentation of the number of previous physical therapy sessions and, if the number of treatments have exceeded guidelines, remaining functional deficits that would be considered exceptional factors to justify exceeding guidelines. In addition, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of physical therapy provided to date. Therefore, based on guidelines and a review of the evidence, the request for physical therapy once a week for six weeks is not medically necessary.

DME to facilitate functional capacity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, Durable medical equipment (DME) Other Medical Treatment Guideline or Medical Evidence: Medical practice standard of care

Decision rationale: MTUS does not address this issue. ODG identifies documentation that the requested durable medical equipment (DME) can withstand repeated use (i.e. could normally be

rented, and used by successive patients); and is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury, as criteria necessary to support the medical necessity of durable medical equipment. Medical Treatment Guideline/Medical practice standard of care criteria necessitate/makes it reasonable to require documentation of which specific DME is being requested as well as a diagnosis/condition (with subjective/objective findings) for which the requested DME is indicated, as criteria necessary to support the medical necessity of DME. Within the medical information available for review, there is documentation of diagnoses of lumbar disc syndrome and myofascitis. However, there is no documentation of which specific DME is being requested as well as a diagnosis/condition (with subjective/objective findings) for which the requested DME is indicated. Therefore, based on guidelines and a review of the evidence, the request for DME to facilitate functional capacity is not medically necessary.

Shockwave Therapy L/S: 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) Low Back, Shockwave Therapy

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Shock wave therapy

Decision rationale: MTUS does not address this issue. ODG identifies that the available evidence does not support the effectiveness of ultrasound or shock wave for treating LBP and that in the absence of such evidence, the clinical use of these forms of treatment is not justified and should be discouraged. Therefore, based on guidelines and a review of the evidence, the request for shockwave therapy L/S is not medically necessary

Ortho consult: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Introduction Page(s): 1.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Independent Medical Examinations and consultations, page(s) 127

Decision rationale: MTUS reference to ACOEM guidelines identifies that consultation is indicated to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work, as criteria necessary to support the medical necessity to support the medical necessity of consultation. Within the medical information available for review, there is documentation of diagnoses of lumbar disc syndrome and myofascitis. However, there is no documentation that consultation is indicated to aid in the diagnosis, prognosis, therapeutic management, determination of medical

stability, and permanent residual loss and/or the examinee's fitness for return to work. Therefore, based on guidelines and a review of the evidence, the request for ortho consult is not medically necessary.