

Case Number:	CM15-0125902		
Date Assigned:	07/10/2015	Date of Injury:	02/15/2012
Decision Date:	09/24/2015	UR Denial Date:	06/24/2015
Priority:	Standard	Application Received:	06/30/2015

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: New York

Certification(s)/Specialty: Internal Medicine

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 54-year-old male, who sustained an industrial injury on 2/15/12. The injured worker was diagnosed as having left S1 radiculopathy, C5-T1 facet arthropathy, severe disc degeneration C4-T1, moderately severe stenosis C4-T1 bilaterally, left arm radiculopathy and status post C5-T1 ACDF. Treatment to date has included oral medications including Restoril, Ultram, Dilaudid, Amlodipine, Aspirin, Hydrochlorothiazide and simvastatin. Currently on 5/22/15, the injured worker complains of pain and burning in lower back rated 3/10 with medications and 7/10 without medications, he notes it has worsened over the past 6 weeks. Urine drug screen performed on 5/22/15 noted inconsistencies with medications prescribed. Current work status is not documented. Physical exam dated 5/22/15 noted an antalgic gait and restricted lumbar range of motion. The treatment plan included a request for physical therapy 2 times a week for 4 weeks, a Medrol dose pack and Ibuprofen 800mg. He is encouraged to utilize ice and heat therapy as tolerated.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 2x4 lumbar: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment in Workers' Compensation, Low Back Procedure Summary Online Version last updated 05/15/2015.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299, Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter.

Decision rationale: MTUS and ODG guidelines recommend 10 physical therapy visits over 8 weeks for medical management of Lumbar sprains and strains and Intervertebral disc disorders without myelopathy. As time goes, one should see an increase in the active regimen of care or decrease in the passive regimen of care and a fading of treatment of frequency (from up to 3 or more visits per week to 1 or less). When the treatment duration and/or number of visits exceeds the guidelines, exceptional factors should be noted. Documentation fails to provide details of previously prescribed physical therapy or the injured worker's response to treatment. Work status is not documented. There is no evidence of exceptional factors to establish the medical necessity for additional active physical therapy. The request for Physical therapy 2x4 lumbar is not medically necessary by MTUS.

Medrol dose pak #1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment in Workers' Compensation Pain Procedure Summary Online Version last updated 06/15/2015, Official Disability Guidelines-Treatment in Workers' Compensation, Low Back Procedure Summary Online Version last updated 05/15/2015.

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 Chapter, Corticosteroids (oral/parenteral/IM for low back pain).

Decision rationale: ODG does not recommend Medrol Dose Pack (corticosteroids) for the treatment of chronic pain. It may be used in limited circumstances for acute radicular pain. The criteria for use of corticosteroids for low back pain includes the presence of clear-cut signs and symptoms of radiculopathy, documentation of discussion with the patient regarding risks of steroids, the fact that research provides limited evidence of effect with this medication and current research indicates early treatment is most successful. Treatment in the chronic phase should be after a symptom free period with subsequent exacerbation or evidence of new injury. Documentation does not support trial of first line treatment options such as non-steroidal analgesics or non-narcotics and there is lack of documentation that the risk of Medrol has been discussed with the injured worker. The request for Medrol Dose Pack is not medically necessary per guidelines.

