

Case Number:	CM15-0074386		
Date Assigned:	04/22/2015	Date of Injury:	09/10/2014
Decision Date:	06/25/2015	UR Denial Date:	03/06/2015
Priority:	Standard	Application Received:	04/07/2015

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

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 41-year-old male, who sustained an industrial/work injury on 9/10/14. He reported initial complaints of back pain. The injured worker was diagnosed as having lumbar sprain/strain, thoracic or lumbosacral neuritis or radiculitis. Treatment to date has included medication, diagnostics, and physical therapy. Currently, the injured worker complains of intermittent sharp low back pain and stiffness with numbness and tingling. Per the primary physician's progress report (PR-2) on 2/17/15, examination revealed tenderness over the coccyx, lumbar paravertebral musculature, sacrum, and spinous processes, muscle spasm in the bilateral gluteus and lumbar paravertebral musculature, positive straight leg raise and Lasegue's tests. The requested treatments include Physical Therapy, Massage, Ultrasound, Mechanical Traction, Diathermy, Infrared to Increase range of motion (ROM)/ activities of daily living (ADL's) and Decrease Pain/Spasms, Consultation with Pain Management Specialist, Cardio-Respiratory Diagnostic Testing (Autonomic Function Assessment), and Pulmonary and Respiratory Diagnostic Testing Including A Sleep Disordered Breathing (SBD) Study.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy, Massage, Ultrasound, Mechanical Traction, Diathermy, Infrared to Increase ROM/ADL's and Decrease Pain/Spasms 6 Sessions (1x6): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 98-99 of 127. Decision based on Non-MTUS Citation ODG, Low Back Chapter, Physical Medicine.

Decision rationale: Regarding the request for Physical Therapy, Massage, Ultrasound, Mechanical Traction, Diathermy, Infrared to Increase ROM/ADL's and Decrease Pain/Spasm, Chronic Pain Medical Treatment Guidelines recommend a short course (10 sessions) of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, there is no documentation of specific objective functional improvement from previous physical therapy sessions and remaining deficits that cannot be addressed within the context of an independent home exercise program yet are expected to improve with formal supervised therapy. In light of the above issues, the currently requested Physical Therapy, Massage, Ultrasound, Mechanical Traction, Diathermy, Infrared to Increase ROM/ADL's and Decrease Pain/Spasm is not medically necessary.

Consultation with Pain Management Specialist: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

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

Decision rationale: Regarding the request for consultation, California MTUS does not address this issue. ACOEM supports consultation if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. Within the documentation available for review, it does not appear that the purpose of the consultation is to consider invasive treatment options, but the patient's current symptoms / findings are not suggestive of the need for any specific interventional treatment, nor is there another clear indication for pain management consultation at this point. In the absence of such documentation, the currently requested consultation is not medically necessary.

Cardio-Respiratory Diagnostic Testing (Autonomic Function Assessment): 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).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation http://www.anthem.com/ca/medicalpolicies/policies/mp_pw_c160708.htm.

Decision rationale: Regarding the request for Cardio-Respiratory Diagnostic Testing (Autonomic Function Assessment), CA MTUS and ODG do not address the issue. Anthem cites that autonomic testing is considered investigational and not medically necessary for all indications. In light of the above issues, the currently requested Cardio-Respiratory Diagnostic Testing (Autonomic Function Assessment) is not medically necessary.

Pulmonary and Respiratory Diagnostic Testing Including A Sleep Disordered Breathing (SBD) Study: 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).

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

Decision rationale: Regarding the request for Pulmonary and Respiratory Diagnostic Testing Including a Sleep Disordered Breathing (SBD) Study, California MTUS guidelines are silent. ODG states Polysomnograms/sleep studies are recommended for the combination of indications listed below: Excessive daytime somnolence, Cataplexy (muscular weakness usually brought on by excitement or emotion, virtually unique to narcolepsy), Morning headache (other causes have been ruled out), Intellectual deterioration (sudden, without suspicion of organic dementia), Personality change (not secondary to medication, cerebral mass or known psychiatric problems), Sleep-related breathing disorder or periodic limb movement disorder is suspected, Insomnia complaint for at least six months (at least four nights of the week), unresponsive to behavior intervention and sedative/sleep-promoting medications and psychiatric etiology has been excluded. Within the documentation available for review, there is no indication of any symptoms or findings suggestive of any pulmonary disorders and none of the criteria outlined above have been met. In the absence of such documentation, the currently requested Pulmonary and Respiratory Diagnostic Testing Including A Sleep Disordered Breathing (SBD) Study is not medically necessary.