

Independent Medical Review Final Determination Letter

1236
[REDACTED]
[REDACTED]
[REDACTED]

Dated: 12/23/2013

IMR Case Number:	CM13-0018816	Date of Injury:	11/16/2004
Claims Number:	[REDACTED]	UR Denial Date:	08/27/2013
Priority:	STANDARD	Application Received:	08/30/2013
Employee Name:	[REDACTED]		
Provider Name:	[REDACTED] MD		
Treatment(s) in Dispute Listed on IMR Application:			
MRI WITH AND WITHOUT CONTRAST, LUMBAR SPINE; PHYSICAL THERAPY TWO TIMES A WEEK FOR FOUR WEEKS, LOWER BACK QUANTITY : 6; HOME CARE TO ASSIST WITH HOUSEWORK DUE TO PAIN, LOWER BACK; MEDICATION OPAN IR 10MG ONE TABLET (EXCEEDED MAXIMUM CHARACTER CAPACITY)			

DEAR [REDACTED] ,

MAXIMUS Federal Services has completed the Independent Medical Review (“IMR”) of the above workers’ compensation case. This letter provides you with the IMR Final Determination and explains how the determination was made.

Final Determination: UPHOLD. This means we decided that none of the disputed items/services are medically necessary and appropriate. A detailed explanation of the decision for each of the disputed items/services is provided later in this letter.

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers’ Compensation. This determination is binding on all parties.

In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers’ Compensation Appeals Board within 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations, [REDACTED]

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Internal Medicine and Pulmonary Diseases 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 physician 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.

DOCUMENTS REVIEWED

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- [REDACTED]
- [REDACTED]
- [REDACTED]
- [REDACTED]

CLINICAL CASE SUMMARY

The physician reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The patient is a 55-year-old female who reported an injury on 11/16/2004. Current diagnoses include lumbar radiculopathy, secondary depression, insomnia, stomach upset and GI side effects, right knee pain, and status post motor vehicle accident and back strain. The patient was most recently seen by Dr. [REDACTED] on 10/01/2013. The patient continued to report increasing pain which has worsened since 07/2013. The patient stated that her medication regimen did help but not very well, and she was still having difficulty performing activities of daily living and housework chores. Current complaints included low back pain, right hip pain, depression, sleep difficulty, gastrointestinal upset, knee pain, and intermittent bowel and urine incontinence. Current pain rating on VAS was 8/10 with medications and 10/10 without medications. Physical examination revealed positive straight leg raising on the right, 40% to 80% normal range of motion of the lumbar spine, and decreased sensation to the right lower extremity. Recommendations included authorization for an MRI of the lumbar spine, physical therapy twice per week for 4 weeks, orthopedic consultation for right knee pain, authorization for home health care, and continuation of current medications.

IMR DECISION(S) AND RATIONALE(S)

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

1. Physical therapy two times a week for four weeks lower back is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Physical medicine, pg 98, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Physical medicine, pg 98, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The guidelines state active therapy requires an internal effort by the individual to complete a specific exercise or task. Active therapy is based on the philosophy that therapeutic exercise and/or activity is beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. The 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. Treatment for radiculitis, neuritis, or neuralgia unspecified includes 8 to 10 visits over 4 weeks. As per the clinical notes submitted, the employee's physical examination revealed moderate spasm of the paralumbar muscles, 40% to 80% normal range of motion, positive straight leg raising, and decreased sensation in the right lower extremity. The employee is now 9 years status post initial injury. It is documented that the employee received temporary benefit from prior physical therapy courses. However, documentation of the significant functional improvement following therapy was not provided. **The requested physical therapy two times a week for four weeks lower back.**

2. Home care to assist with housework due to pain lower back is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Home health services pg 51, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Home health services pg 51, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The guidelines state home health services are recommended only for otherwise recommended medical treatment for individuals who are homebound, on a part-time or intermittent basis, generally up to no more than 35 hours per week. Medical treatment does not include homemaker services like shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed. As per the clinical note on 10/01/2013, the provider notes that the employee is not bed bound or homebound, and requests home health assistance with housework. **The requested home care to assist with housework due to pain lower back is not medically necessary and appropriate.**

3. Soma 350mg one tablet t.i.d. for muscle spasm control quantity 90 is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Carisoprodol (Soma), pg 29, which is part of the MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Carisoprodol (Soma), pg 63-66 and 124, which is part of the MTUS.

The Physician Reviewer's decision rationale:

The guidelines state muscle relaxants are recommended as non-sedating second line option for short-term treatment of acute exacerbations in individuals with chronic low back pain. In lower back pain cases, they show no benefit beyond NSAIDs in pain and overall improvement. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. Soma is recommended for no longer than a 2 to 3 week period. As per the clinical notes submitted, the employee does demonstrate muscle spasms on physical examination. However, there is no documented functional improvement from its previous use in this case. The employee's physical examination remains unchanged from previous office visits. **The requested Soma 350mg one tablet t.i.d. for muscle spasm control quantity 90 is not medically necessary and appropriate**

Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]