

Case Number:	CM13-0038602		
Date Assigned:	05/02/2014	Date of Injury:	03/19/2013
Decision Date:	06/11/2014	UR Denial Date:	10/10/2013
Priority:	Standard	Application Received:	10/25/2013

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain 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:

The patient is a 29 year old female who was injured on 03/19/2013. Mechanism of injury is unknown. Prior treatment history was not documented showing any physical therapy or medication records. The patient underwent right piriformis Botox chemodenervation with hyaluronidase under ultrasound guidance on 12/04/2013. PR-2 dated 07/09/2013 documented the patient with complaints of low back pain rated 7/10 radiating to the right lower extremity with sharp pain. Objective findings on examination of the lumbar spine reveal positive SLRs on the right at 30 degrees. Positive Braggard's and sciatic notch test on the right, greater than left. There is restricted range of motion. Positive Patrick's FABER (for low back pain only). There is decreased sensation on L4-L5 dermatome on the right. The patient has difficulty standing from a seated position and sitting and standing position. PR-2 dated 02/18/2014 documented the patient with complaints of low back pain which she rates as 8/10 radiating to both upper extremities with sharp pain, tingling and soreness. Diagnoses: 1. Lumbar intervertebral disc displacement without myelopathy. 2. Right lower extremity radiculopathy. Treatment Plan: Requesting physical therapy two times a week for four weeks for the lumbar spine. UR report dated 10/10/2013 denied the request for Physical Therapy 2x a week for 4 weeks to the lumbar spine because there is no documentation submitted for review that provides evidence of the amount of sessions completed with total duration and objective functional improvements during and upon completion of treatment. The patient reported on more than one occasion that she felt no improvement and actual exacerbation of symptoms following physical therapy, with no changed or improvement in physical examination documented by the physician. Based on the clinical information submitted for this review and using evidence-based, peer-reviewed guidelines referenced, this request is not medically necessary and appropriate.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY 2 X PER WEEK FOR 4 WEEKS FOR THE LUMBAR SPINE:

Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
PHYSICAL MEDICINE Page(s): 98-99.

Decision rationale: The CA MTUS and (ODG) Official Disability Guidelines recommend physical therapy for/as short term relief during the acute phase of injury in order to control pain and inflammation, and to improve the rate of healing for soft tissue injuries. The guidelines recommend using active treatment modalities such as home exercise programs, education, and activity modification over passive modalities, such as physical therapy. The medical records document the patient had worsening of symptoms with prior physical therapy. Further, the documents show no information regarding a home exercise program or other treatment modalities that emphasize an active patient role. Based on the CA MTUS and ODG guidelines and criteria as well as the clinical documentation stated above, the request is not medically necessary. The request is not medically necessary and appropriate.