

Case Number:	CM13-0041181		
Date Assigned:	12/20/2013	Date of Injury:	10/09/2009
Decision Date:	02/18/2014	UR Denial Date:	09/30/2013
Priority:	Standard	Application Received:	10/13/2013

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 is licensed to practice in New York. 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. 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 70 year old female with a date of injury of 10/09/2009. She was over-reaching trying to store a heavy box on a high shelf and had low back pain. The diagnosis was a lumbar sprain. She was treated with medication and 6 visits of physical therapy. Despite a normal neurologic exam, on 11/23/2009 a lumbar MRI was done and revealed disc protrusion at L4-L5 and L5-S1. On 12/17/2009 she had an epidural injection and a second one was done in 01/2010. On 01/27/2010 she had a normal gait with a normal lumbar range of motion. There was no weakness. Straight leg raising was negative. Reflexes and sensation were normal. She had additional physical therapy in 2010. On 09/28/2012 strength, sensation and reflexes were normal. She continued to have low back pain. On 10/26/2012 she had another epidural steroid injection. On 12/14/2012 the strength was 5/5 and there were normal reflexes. Sensation was normal. Straight leg raising was positive bilaterally. [REDACTED] records noted that she had 43 physical therapy visits from 09/21/2012 to 10/09/2013. On 02/01/2013 during physical therapy visit 28 it was noted that her low back pain was "feeling pretty good today." On 02/15/2013 during visit 31, again it was noted "low back pain feeling pretty good today." There were no measurements of range of motion or strength during either visit note. She was doing a home exercise program. On 10/09/2013 she had lumbar spasm with pain on lumbar motion. Thus she had at least 49 recent physical therapy visits. On 10/15/2013 it was noted that she was doing a home exercise program. On 11/25/2013 there was a request for physical therapy for 6 visits.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy (PT) for Lumbar Spine: 6 visits: 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 Chronic Pain Medical Treatment Guidelines Page(s): 98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) 2014, Lumbar strain.

Decision rationale: The MTUS guidelines using ACOEM do not address the number of physical therapy visits for a lumbar strain/sprain. However, in the 2014 ODG the maximum number of physical therapy visits allowed is 10 visits over an 8 week period. This patient had more than 49 visits in 2012 - 2013 and other courses of physical therapy in 2009 and 2010. She had more visits over a greater period of time than in the ODG. The description of the MRI in 2009 is disc bulges in L4-L5 and L5-S1, yet every person aged 60 to 70 will have that finding. She had numerous examinations with normal strength, normal sensation and normal reflexes. Gait was normal. Range of motion was normal. Her main issue is chronic low back pain. The MTUS guidelines for chronic pain require objective documentation of improved functional ability to do activities of daily living. This has never been documented. Furthermore, it is difficult to document improvement when during multiple examinations it appears that she is fully functional. She already had more physical therapy visits than allowed under the chronic pain section of MTUS and there is no documented improved ability to do activities of daily living. By this point in time she should have been transitioned to a home exercise program. She has been instructed in a home exercise program and has been doing this. There is no objective documentation that continued formal physical therapy is superior to a home exercise program.