

Case Number:	CM13-0046543		
Date Assigned:	12/27/2013	Date of Injury:	10/20/2011
Decision Date:	05/15/2014	UR Denial Date:	10/22/2013
Priority:	Standard	Application Received:	11/01/2013

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 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:

This 35 year-old male sustained an injury on 10/20/11 while employed by [REDACTED]. Request under consideration include Physical Therapy 2 x week x 4 weeks Lumbar Spine. Report of 6/27/13 from the provider noted patient with low back pain across the back radiating down the left leg and posterior thigh without numbness or tingling. Diagnoses included lumbar radiculopathy and post lumbar fusion. Report of 9/10/13 noted patient with low back pain with diagnoses to include s/p lumbar discectomy, depression, and insomnia. Exam indicated decreased range of lumbar motion; tenderness of paravertebral muscles and sensorimotor deficit at L4-L5. Report of 10/16/13 noted unchanged low back pain s/p surgery. Exam showed tenderness and sensorimotor deficit in L4-5 on the right. [REDACTED] has included medications, physical therapy, sacroiliac block, lumbar epidural steroid injection in March 2013, off work, and surgery with L4-5 disc replacement on 2/15/12. Request for physical therapy to the lumbar spine was non-certified on 10/22/13 citing guidelines criteria and lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy 2 x week x 4 weeks Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 99.

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

Decision rationale: This 35 year-old male sustained an injury on 10/20/11 while employed by [REDACTED]. Request under consideration include Physical Therapy 2 x week x 4 weeks Lumbar Spine. Report of 6/27/13 from the provider noted patient with low back pain across the back radiating down the left leg and posterior thigh without numbness or tingling. Diagnoses included lumbar radiculopathy and post lumbar fusion. Report of 9/10/13 noted patient with low back pain with diagnoses to include s/p lumbar discectomy, depression, and insomnia. Exam indicated decreased range of lumbar motion; tenderness of paravertebral muscles and sensorimotor deficit at L4-L5. Report of 10/16/13 noted unchanged low back pain s/p surgery. Exam showed tenderness and sensorimotor deficit in L4-5 on the right. [REDACTED] has included medications, physical therapy, sacroiliac block, lumbar epidural steroid injection in March 2013, off work, and surgery with L4-5 disc replacement on 2/15/12. Present complaints are continued chronic pain with exam showing tenderness and decreased range, but without identified neurological deficits. Submitted reports have no acute flare-up or specific physical limitations to support for physical therapy. Physical therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. There is unchanged chronic symptom complaints, clinical findings, and work status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. The Chronic Pain Guidelines allow for 9-10 visits of physical therapy with fading of treatment to an independent self-directed home program. The Physical Therapy 2 x week x 4 weeks Lumbar Spine is not medically necessary and appropriate.