

Case Number:	CM13-0054007		
Date Assigned:	12/30/2013	Date of Injury:	07/12/2011
Decision Date:	06/04/2014	UR Denial Date:	10/31/2013
Priority:	Standard	Application Received:	11/12/2013

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 Orthopaedic Surgery 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. 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 injured worker is a 61-year-old male with report of industrial injury on July 12, 2011. The mechanism of injury is reported as lifting bottles of wine while performing job duties as a Packing Tech. The subsequent diagnosis is recorded as lumbar spondylosis. The progress note dated September 26, 2012 indicated some improvement with cold packs for pain, however, a return to work 4 hours a day is noted. There is increased pain with hyperextension of the low back. Physical examination noted tenderness to palpation in the lower lumbar region and hip flexion to be 90°. The diagnosis was lumbar strain with radiculopathy. The injured worker continued to be symptomatic and a Qualified Medical Evaluation was sought. The claimant continued on modified work status. There is a notation of a request for postoperative physical therapy. This request was not certified. The noncertification indicated a solid decreased lumbar spine range of motion, manual muscle testing to be within normal limits, and there is no step off for instability noted. MRI noted degenerative disc disease and facet disease. Transition to home exercise protocol is suggested. An October evaluation for additional physical therapy noted the requesting provider to be uncertain as to the efficacy of any additional physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

POST OP PHYSICAL THERAPY TWO TIMES A WEEK FOR SIX WEEKS: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Post Surgical Rehabilitation.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Postsurgical Treatment Guidelines.

Decision rationale: When noting the date of injury, the date of surgery, and the physical therapy completed preoperatively and postoperatively; is also said to respond to other pain interventions and the parameters noted in the California Medical Treatment Utilization Schedule, there is insufficient data presented to suggest any additional postsurgical treatment would be warranted. Furthermore, any intervention should be completed within four months of the date of surgery. Given the time frames noted, the parameters are not met. As such, the request for post op physical therapy two times a week for six weeks is not medically necessary