

Case Number:	CM13-0066543		
Date Assigned:	01/03/2014	Date of Injury:	04/28/2013
Decision Date:	05/21/2014	UR Denial Date:	11/21/2013
Priority:	Standard	Application Received:	12/16/2013

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 Occupational 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 male who was injured on 4/28/13. While he was cleaning and repositioning a sedated patient, he began to develop pain and tightness in his lower back. Prior Final Determination Letter for IMR Case Number CM13-0066543 3 treatment history has included nerve block injection. He was given one series of epidurals and underwent lumbar micro discectomy and laminectomy on 6/26/13. He has had physical therapy three times a week. His medications include Percocet, Mobic, and anti-inflammatory agents. A progress note dated 9/10/13 documented the patient to have complaints of continuous aching and stiffness in the lower back, at times becoming dull and shooting pain. His pain continues to travel to his left leg and calf, but is improving. He states that coughing and sneezing aggravate his lower back pain. His left leg is weaker than the right. His pain increases with prolonged standing, walking, sitting, and driving. His pain also increases with bending, twisting, and turning, especially in a quick manner. Physical therapy and pain medication provide him pain improvement, but he remains symptomatic. He wears a back support intermittent throughout the day. Objective findings on examination of the lumbar spine reveal there is somewhat flattened lumbar lordosis. There is poor abdominal strength. Flattening of the normal lumbar lordosis is noted. There is a well-healed midline scar of approximately 1 cm. Range of motion of the lumbar spine is within normal limits. Examination of the lower extremities shows a normal stance and gait. The patient squats fully and rises without aids. The patient can toe and heel walk with ease. Lower extremity neurologic exam is within normal limits. Sensation to light touch and pinprick as tested by a Wartenberg are within normal limits. No sensory deficits are noted. Motor muscle testing is 5/5 bilaterally in all muscle groups. The patient is to continue his course of physical therapy, and begin a range of motion, flexibility, and core strengthening program three times a week for four weeks. A PR-2 dated 10/30/13 documented that the patient is making progress in physical

therapy. The patient's current pain is at 1/10. His worst complaints is 5/10 pain. The patient is able to perform his activities of daily living, household chores, and ambulate with slight complaints. His limitations include heavy lifting, twisting, jogging, running, prolonged sitting, and working. Objective findings on exam reveal that his lumbar range of motion was not tested. The lower extremity knee flexion was 5/5, extension was 5/5, and hip flexion was not tested. The treating physician believes that the patient has made progress with physical therapy, and would benefit from continuing with physical therapy to progress with functional activities. A PR-2 dated 11/19/13 documented that the patient completed 42 sessions of physical therapy. He complains of hip tightness, but no numbness. Objective findings reveal lumbar flexion is at 30 degrees. He has pain with straight leg rising. His diagnosis is herniated nucleus pulposus of the lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

ADDITIONAL PHYSICAL THERAPY 2-3 TIMES A WEEK FOR 4-6 WEEKS FOR THE LUMBAR SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines

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

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that active therapy is helpful for restoring flexibility, strength, endurance, function, and range of motion. It can also alleviate discomfort. This form of therapy may require supervision from a therapist or medical provider, but patients are instructed and expected to continue active therapies at home as an extension of the process. Active therapy should allow for the fading of treatment frequency from up to three visits per week to one or less, as the patient relies more on self-directed home therapy. Guidelines recommend 9-10 physical therapy visits over eight weeks for myalgia and myositis; 8-10 visits over four weeks for neuralgia, neuritis, and radiculitis; and 24 visits over 16 weeks for reflex sympathetic dystrophy. This patient has had extensive physical therapy (approximately 42 sessions). His clinical history indicates that he should have enough experience to transition to a home-based exercise program. There is a lack of reasoning to deviate from guideline recommendations; therefore, the request for additional physical therapy is not medically necessary.