

Case Number:	CM14-0101152		
Date Assigned:	07/30/2014	Date of Injury:	06/14/2011
Decision Date:	10/14/2014	UR Denial Date:	06/23/2014
Priority:	Standard	Application Received:	07/01/2014

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 New York and Texas. 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 injured worker is a 45 year old male whose date of injury is 06/14/2011. A transmission fell on the injured worker as he was working on a truck. Diagnoses are backache nos, pain in joint, cervical pain, RSD upper limb, lumbar radiculopathy, and carpal tunnel syndrome. Treatment to date includes modified duty, medication management, back support, arm sling, cervical roll, ORIF right thumb on 06/21/11, occupational therapy, medial branch block L3-5. The injured worker has completed at least 18 physical therapy visits to date. Office visit dated 07/31/14 indicates that he denies any new injury. Medications include Hydrocodone-Acetaminophen, Ambien and Pantoprazole. Lumbar range of motion is restricted with flexion 50 degrees and extension 10 degrees. Facet loading is positive on the left. Straight leg raising is negative. Faber is negative. Motor exam is normal. This note states that the injured worker has failed conservative treatment including physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy-Lumbar spine 2 times 6: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Physical therapy

Decision rationale: Based on the clinical information provided, the request for physical therapy lumbar spine 2 times 6 is not recommended as medically necessary. The injured worker has completed at least 18 physical therapy visits to date with no documentation of new injury. The Official Disability Guidelines support up to 12 sessions of physical therapy for the patient's diagnosis, and there is no clear rationale provided to support exceeding this recommendation. There are no exceptional factors of delayed recovery documented. Per note dated 07/31/14, the injured worker has failed conservative therapy including physical therapy. The injured worker has completed sufficient formal therapy and should be capable of continuing to improve strength and range of motion with an independent, self-directed home exercise program.