

Case Number:	CM14-0103654		
Date Assigned:	07/30/2014	Date of Injury:	01/04/2014
Decision Date:	08/29/2014	UR Denial Date:	06/20/2014
Priority:	Standard	Application Received:	07/04/2014

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 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:

Injured worker is a 56-year-old female with an industrial injury on 01/04/14. The patient sustained an injury while working for [REDACTED] on 01/04/2014. She was previously referred for therapy. She also reports that in February, 2014 she sustained a myocardial infarction. The patient is still weak and she is slowly recovering. She is currently following up with her cardiologist at [REDACTED]. The patient reports that her symptoms are improving gradually. Examination of her back revealed lumbosacral paraspinal muscle spasms with tender areas over the lower lumbosacral facet joint. She complains of low back pain and she rates her pain to be 7 out of 10 with no numbness or tingling sensation problems. On straight-leg raise testing in sitting position, the patient has tightness in the back. The patient's gait is antalgic. The diagnosis is low back pain. An MRI of Lumbar Spine w/o contrast dated February 10, 2014 showed bilateral degenerative facet joints L5-S1 and multilevel mild broad-based disc bulges, most notable at L5-S1. Prior request of Physical Therapy for six additional sessions was found to be medically unnecessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

6 Additional physical therapy session: 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.

Decision rationale: As per CA MTUS Chronic Pain Medical Guidelines, physical medicine is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. The guidelines recommend 9 visits over 8 weeks for intervertebral disc disorders without myelopathy, 10 visits over 8 weeks for lumbar sprains and strains, or lumbago/backache. CA MTUS, Physical Medicine recommends: Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. In this case, there is no record of prior physical therapy progress notes with documentation of any significant improvement in the objective measurements (i.e. pain level, range of motion, strength or function) to demonstrate the effectiveness of physical therapy in this injured worker. Furthermore, there is no mention of the patient utilizing an Home Exercise Program. (At this juncture, this patient should be well-versed in an independently applied Home Exercise Program with which to address residual complaints, and maintain functional levels). There is no evidence of presentation of an acute or new injury with significant findings on examination to warrant additional treatments. Therefore, the request is considered not medically necessary or appropriate in accordance with the guidelines.