

Case Number:	CM14-0114308		
Date Assigned:	09/16/2014	Date of Injury:	06/25/2013
Decision Date:	11/14/2014	UR Denial Date:	06/24/2014
Priority:	Standard	Application Received:	07/21/2014

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:

This 26 year-old patient sustained an injury on 6/25/13 from pushing a lawnmower, lost his balance and fell while employed by [REDACTED]. Requests under consideration include Physical Therapy 3 times 4 weeks for Infrared Massage, Myofascial Release, Iontophoresis/Electro Stimulation. Diagnoses included thoracic spine and lumbar spine sprain/disc disorder and protrusion. Report of 2/4/14 from the provider noted the patient with mid/lower back pain and hip pain. Exam showed paraspinal spasm; tenderness; limited range; decreased sensation diffusely at L4, L5 and S1 dermatomes that is not reproducible. Diagnoses included thoracic spine sprain/strain; and lumbar spine sprain/strain with radiating to bilateral lower extremities. Treatment included medications, interferential (IF) therapy unit, physical therapy (PT), electromyography (EMG)/nerve conduction velocity (NCV), X-rays, MRIs, urine drug screening UDS, and functional capacity evaluation (FCE). Hand-written report of 5/30/14 from the provider noted the patient with chronic ongoing low back pain without radiculopathy. Exam showed positive straight leg raise and positive Kemp's test bilaterally. The requests for Physical Therapy 3 times 4 weeks for Infrared Massage, Myofascial Release, Iontophoresis/Electro Stimulation was non-certified on 6/24/14 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 3 times 4 weeks, Infrared Massage, Myofascial Release, Iontophoresis/Electro Stimulation: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines Page(s): 98-99.

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

Decision rationale: 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. However, there is no clear measurable evidence of progress with the PT treatment already rendered including milestones of increased range of motion (ROM), strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, 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. It appears the employee has received significant therapy sessions without demonstrated evidence of functional improvement to allow for additional therapy treatments. There is no report of acute flare-up, new injuries, or change in symptom or clinical findings to support for formal PT in a patient that has been instructed on a home exercise program for this chronic injury. Submitted reports have not adequately demonstrated the indication to support further physical therapy when prior treatment rendered has not resulted in any functional benefit. The request for Physical Therapy 3 times 4 weeks for Infrared Massage, Myofascial Release, Iontophoresis/ Electro Stimulation is not medically necessary and appropriate.