

Case Number:	CM14-0126521		
Date Assigned:	08/13/2014	Date of Injury:	01/08/2014
Decision Date:	09/18/2014	UR Denial Date:	07/23/2014
Priority:	Standard	Application Received:	08/08/2014

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 & Rehabilitation and is licensed to practice in Illinois. 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 57-year-old female who reported an injury on 01/08/2014. The mechanism of injury was not provided in the medical records. The clinical note dated 07/01/2014 indicated the injured worker reported pain in the right side of the low back and tailbone area. The injured worker reported the pain was intermittent from there into her hip and occasionally goes down her right leg. The injured worker reported pain in her back and her legs and reported the right leg was worse than the left. The injured worker also reported she had coccyx and hip pain described as fire and radiated down her legs. She reported the pain was continuous; however, it did vary in intensity. The injured worker reported her pain 9/10 and can get as high as 10/10. The injured worker reported the only relief from the pain was occasionally when she would lie flat with her knees elevated. The injured worker reported she had utilized Mobic and hydrocodone. The injured worker reported her pain was aggravated with standing, sitting, walking, bending, and work and relived with lying down in a "good position." The injured worker reported numbness and tingling in her right leg and trouble with stumbling and tripping and balance issues. The injured worker reported she did use a cane when walking outside. She reported she had done 2 sessions of physical therapy with no relief. The treatment plan included possible epidural steroid injection, prescription for more physical therapy. The injured worker's prior treatments included diagnostic imaging and physical therapy and medication management. The provider submitted a request for physical therapy. A request for authorization dated 07/16/2014 was submitted for physical therapy; however, rationale was not provided for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy 3 X 8 weeks Lumbar Spine: Upheld

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

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

Decision rationale: The California MTUS state that active therapy 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. Active therapy requires an internal effort by the individual to complete a specific exercise or task. The guidelines note injured workers are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. It was indicated the injured worker had prior physical therapy in a document dated 04/16/2014. The injured worker had completed 8 physical therapy visits. In addition, there is lack of documentation including an adequate and complete physical exam demonstrating the injured worker has decreased functional ability, decreased range of motion, decreased strength, or flexibility. In addition, the injured worker still rates her pain at 9/10, sometimes 10/10, and reports she got no relief from physical therapy. There is no indication that the use of physical therapy has resulted in efficacy or functional improvement. Moreover, the request for physical therapy was modified for 4 sessions on 07/23/2014. Furthermore, completed physical therapy should have been adequate to improve functionality and transition the injured worker to a home exercise program where the injured worker may continue with exercises such as strengthening, stretching, and range of motion. Therefore, the request for Physical Therapy 3 X 8 weeks Lumbar Spine is not medically necessary.