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| Case Number: | CM14-0145152 | | |
| Date Assigned: | 09/12/2014 | Date of Injury: | 05/11/2010 |
| Decision Date: | 11/05/2014 | UR Denial Date: | 08/15/2014 |
| Priority: | Standard | Application Received: | 09/08/2014 |

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 and Rehabilitation and is licensed to practice in 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:

Medical records reflect the claimant is a 47 year old male who sustained a work injury on 5-11-10. The claimant is status post left hemi-laminectomy, discectomy and partial facetectomy at L4-L5 on 7-19-11. The claimant had redo laminectomy with discectomy at L4-L5 on 10-2-12. On 4-30-13 and 5-20-14 the claimant was provided with a lumbar transforaminal injection. Office visit on 7-28-14 notes the claimant has low back pain and left lower extremity pain. On exam, the claimant had some weakness to the left lower extremity and positive SLR.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy, 2 x per week for 6 weeks, for the Lumbar Spine and the Right Knee:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99. Decision based on Non-MTUS Citation ODG Low Back (updated 07/03/14), Physical therapy (PT), and the ODG Knee & Leg (updated 06/05/14), Physical medicine treatment

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

Decision rationale: The Chronic Pain Medical Treatment Guidelines as well as ODG notes that one should allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. There is an absence in documentation noting that this claimant cannot perform a home exercise program. There are no extenuating circumstances to support physical therapy at this juncture, so far removed postop. Therefore, the medical necessity of this request is not established.