

Case Number:	CM14-0176601		
Date Assigned:	10/30/2014	Date of Injury:	02/14/2006
Decision Date:	12/11/2014	UR Denial Date:	09/24/2014
Priority:	Standard	Application Received:	10/24/2014

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 Preventive Medicine 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:

According to the records made available for review, this is a 55-year-old male with a 2/14/06 date of injury, and status post L5-S1 anterior and posterior decompression and instrumented fusion 5/9/13. At the time (9/24/14) of request for authorization for physical therapy three (3) times a week for four (4) weeks, (Diagnosis) (Dx): Thoracic/lumbar disc degeneration, there is documentation of subjective (intermittent low back pain) and objective (motion restricted and does cause painful symptoms, and antalgic gait) findings, current diagnoses (s/p anterior and posterior lumbar interbody fusion L5-S1 5/9/13), and treatment to date (medications, activity modification, trigger point injections, and post-op physical therapy x 24). There is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services as a result of physical therapy completed to date and exceptional factors to justify going outside of guideline parameters.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy three (3) times a week for four (4) weeks, Dx: Thoracic/lumbar disc degeneration: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine, Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Physical Therapy, Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines support a brief course of physical medicine for patients with chronic pain not to exceed 10 visits over 4-8 weeks with allowance for fading of treatment frequency, with transition to an active self-directed program of independent home physical medicine/therapeutic exercise. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG recommends a limited course of physical therapy for patients with a diagnosis of intervertebral disc disorder without myelopathy not to exceed 34 visits over 16 weeks. ODG also notes patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy) and when treatment requests exceeds guideline recommendations, the physician must provide a statement of exceptional factors to justify going outside of guideline parameters. Within the medical information available for review, there is documentation diagnoses of s/p anterior and posterior lumbar interbody fusion L5-S1 5/9/13 and thoracic and lumbar disc degeneration. In addition, there is documentation of 24 post-op physical therapy visits completed to date. However, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services as a result of physical therapy completed to date. In addition, given that the request is for physical therapy three (3) times a week for four (4) weeks which along with the number of visits completed to date, would exceed guidelines, there is no documentation of exceptional factors to justify going outside of guideline parameters. Therefore, the request for physical therapy three (3) times a week for four (4) weeks, Dx: Thoracic/lumbar disc degeneration is not medically necessary, based on guidelines and a review of the evidence.