

Case Number:	CM14-0181578		
Date Assigned:	11/06/2014	Date of Injury:	01/30/2003
Decision Date:	12/12/2014	UR Denial Date:	10/30/2014
Priority:	Standard	Application Received:	10/31/2014

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, has a subspecialty in Interventional Spine Pain Management 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:

The patient is a 69 year old with an injury date on 1/30/03. Patient complains of back soreness with significantly improved right knee and bilateral foot dysesthesias per 7/28/14 report. Patient is making slow progress with respect to right lower extremity weakness, and continues with ongoing left dorsiflexion weakness with episodes of tripping/fatigue per 10/20/14 report. Based on the 10/20/14 progress report provided by [REDACTED] the diagnosis is 7 months s/p posterior spinal fusion and laminectomy, L3-S1, with slow but steady improvement. Exam on 10/20/14 showed "left dorsiflexion weakness, 4/5, and left EHL, 4/5. Ongoing atrophy in right quad, improved compared to pre-op." No range of motion testing was included in reports. Patient's treatment history includes physical therapy, and medications. [REDACTED] is requesting additional physical therapy, QTY 12, and E-stim unit for home use. The utilization review determination being challenged is dated 10/30/14 and modifies request for additional physical therapy from 12 to 7 sessions without a rationale. [REDACTED] is the requesting provider, and he provided treatment reports from 1/13/14 to 10/20/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional physical therapy, quantity 12: Overturned

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98, 99, Postsurgical Treatment Guidelines Page(s): 25, 26.

Decision rationale: This patient presents with back pain, and bilateral leg weakness and is 7 months s/p L3-S1 posterior spinal fusion/laminectomy. The provider has asked for Additional Physical Therapy, QTY 12 on 10/20/14 "to continue focusing on his lower extremity strength and ambulatory capabilities." Consultation of physical therapy reports shows that the patient had 16 physical therapy sessions from 6/16/14 to 10/16/14. In the 7/28/14 report, patient had completed 3 physical therapy sessions and had "significant improvement" of dysesthesias of right knee and bilateral feet. In 9/15/14 report, patient is making "slow and steady progress" and has improved left foot numbness, improved strength in right leg, his knee does not buckle when he goes up/down stairs, returned muscle mass in right thigh, as well as returned sensation to right patellar region. Regarding spinal fusion surgery, MTUS post-surgical guidelines allow 34 visits over 16 weeks within 6 months of surgery. In this case, patient has had 16 sessions of post-operative physical therapy with slow, steady progress. The provider is requesting 12 additional sessions of physical therapy to improve right lower extremity weakness and ambulatory capabilities which appears reasonable for patient's slowly improving postoperative condition. Therefore, this request is medically necessary.

E-Stim unit for home use: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain (transcutaneous electrical nerve stimulation).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular electrical stimulation (NMES devices) Page(s): 121.

Decision rationale: This patient presents with back pain, and bilateral leg weakness. The provider has asked for E-stim unit for home use. Regarding neuromuscular electrical stimulation, MTUS recommends as part of rehabilitative treatment program for stroke, but not indicated for chronic pain. In this case, the patient presents with chronic back pain and lower extremity weakness which is not indicated per MTUS guidelines for use of muscle stimulator. Therefore, this request is not medically necessary.