

Case Number:	CM14-0021272		
Date Assigned:	05/07/2014	Date of Injury:	05/16/2007
Decision Date:	08/12/2014	UR Denial Date:	01/27/2014
Priority:	Standard	Application Received:	02/20/2014

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, has a subspecialty Interventional Spine 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 53-year-old female with date of injury of 05/16/2007. The listed diagnoses per [REDACTED] dated 01/21/2014 are: lumbar degenerative disk disease; lumbar herniated nucleus pulposus; low back pain; lumbar radiculopathy, bilateral l5 and s1 lumbosacral radiculopathy per the Electromyography and Nerve Conduction Velocity study (EMG/NCV) on 01/17/2013; lumbar sprain; lumbar stenosis; sciatica; status post laminectomy, foraminotomy and decompression at l4-l5 and l5-s1 from 06/26/2013; and a history of gastritis. According to this report, the patient reports that her condition has worsened since the last evaluation. She reports continued pain in the lumbar spine which radiates to her bilateral lower extremities down to her toes along with numbness and tingling. Her cervical spine also gives her pain, which radiates to her bilateral upper extremities with associated numbness and tingling. She also reports severe pain in both knees. The objective findings show there is tenderness to palpation, myospasms and limited range of motion in the lumbar spine. Sensation is still present in the patient's lower extremities. There is tenderness to palpation with myospasms noted in the bilateral knees. Restricted range of motion was noted on all planes with pain at the end of motion. The utilization review denied the request on 01/27/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY TWO TIMES A WEEK FOR FOUR WEEKS: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL MEDICINE GUIDELINES Page(s): 104.

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

Decision rationale: This patient presents with lumbar and cervical spine pain. The patient is status post laminectomy and decompression from 06/26/2013 and post surgical guidelines do not apply. The provider is requesting physical therapy 2 times a week for 4 weeks per report 1/21/14. For physical therapy outside the post-surgical guidelines, the MTUS Guidelines pages 98 and 99 on physical medicine recommends 8 to 10 visits for myalgia, myositis, and neuralgia type symptoms. The records do not include therapy reports but the utilization review denial letter notes that the patient received 4 post- operative physical therapy, 6 chiropractic treatments and 12 aquatic therapy visits. The report from 01/21/2014 states that the patient's condition has worsened since the last evaluation, but does not explain what additional therapy is to accomplish. However, given that the patient has only had 4 sessions of land-therapy, the patient may benefit from additional therapy. Chiropractic and Aqua Therapy may have not been very effective. Therefore, Physical Therapy is medically necessary and appropriate.