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| Case Number: | CM14-0026191 | | |
| Date Assigned: | 06/20/2014 | Date of Injury: | 11/09/2007 |
| Decision Date: | 07/31/2014 | UR Denial Date: | 01/30/2014 |
| Priority: | Standard | Application Received: | 02/28/2014 |

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 Sports Medicine and is licensed to practice in Texas and New York. 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 59-year-old female who reported an injury on 11/09/2007. The mechanism of injury was noted to be the injured worker attempting to maneuver a flatbed cart. The injured worker's prior treatments included physical therapy, aqua therapy and acupuncture. The injured worker's diagnoses were noted to be post laminectomy syndrome L3-4, L4-5, and left knee meniscus sprain. She had a clinical evaluation on 12/12/2013. Her chief complaint was noted to be low back pain. The physical examination found the injured worker with normal gait, toe and heel walking was difficult but performable due to reciprocation of buttock, leg and back pain. A review of the lumbar spine indicated tenderness upon palpation in the midline at the level of the iliac crest inferior and superior as well as the bilateral lumbosacral joints and bilateral buttocks. Sitting straight leg raise was positive bilaterally. There were no motor or sensory deficits. However, pain, numbness and tingling were localized to the bilateral anterolateral thighs, stopping at the level of the knee. The treatment plan included a recommendation for lumbar decompression. The provider's rationale for the requested physical therapy was not provided within the documentation. A request for authorization for medical treatment was provided and dated 01/22/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

12 PHYSICAL THERAPY VISITS, 3 VISITS PER WEEK FOR 4 WEEKS.: Upheld

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

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

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines indicate a recommendation for physical medicine. 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 formal therapy may require supervision from a therapist or medical provider such as verbal, visual, and/or tactile instruction. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. The physical medicine guidelines allow for a fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home physical medicine. The guidelines allow for 8 to 10 visits over 4 weeks. The clinical evaluation on 12/12/2013 does not provide current measurable objective functional deficits. The objective findings do not include range of motion values or motor strength numbers. The provider's request for 12 physical therapy visits is in excess of the 8 to 10 recommended by the guidelines. In addition, the provider's request for physical therapy fails to indicate the area or region of the body requiring therapy. Therefore, the request is not medically necessary.