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| Case Number: | CM14-0040597 | | |
| Date Assigned: | 06/20/2014 | Date of Injury: | 07/13/2003 |
| Decision Date: | 07/17/2014 | UR Denial Date: | 03/05/2014 |
| Priority: | Standard | Application Received: | 03/13/2014 |

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 Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 54 year old male who reported an injury on 07/13/2013 due to an unknown mechanism of injury. The injured worker complained of pain in the low back and right lower extremity. He rated his pain 5/10. On 02/24/2014 the physical examination revealed 5/5 strength scores for the bilateral iliopsoas, quadriceps, tibialis anterior, and toe flexors. His lumbar flexion is 80 degrees, and extension is 15 degrees with low back pain. There were no diagnostic studies provided for review. The injured worker has a current diagnosis of lumbar radiculopathy. The past treatment included chiropractic therapy, a right L4-L5 transforaminal epidural steroid injection under fluoroscopic guidance, and right L4-L5 diagnostic epidurograms on 01/07/2014. The injured worker is on the following medications cyclobenzaprine 7.5mg, ketoprofen 50mg, and terocin lotion. The current treatment plan is for physical therapy for the lumbar spine, #8. The rationale and request for authorization form was not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy for the lumbar spine, # 8: Upheld

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

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

Decision rationale: The CAMTUS guidelines state that physical therapy is recommended. Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. 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. It also says that recommended physical therapy for neuralgia, neuritis, and radiculitis, unspecified is 8-10 visits over 4 weeks. The documentation provided does not specify the frequency of the proposed physical therapy. Due to the lack of documentation, the request is not supported at this time.