

Case Number:	CM14-0053812		
Date Assigned:	07/07/2014	Date of Injury:	06/25/1985
Decision Date:	09/03/2014	UR Denial Date:	04/03/2014
Priority:	Standard	Application Received:	04/22/2014

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 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:

This 54 year-old patient sustained an injury on 6/25/1985 while employed by [REDACTED]. Request(s) under consideration include Physical Therapy to the Lumbar 2 x 4. Diagnoses include lumbar spine pain/ radiculitis. Report of 8/26/13 from the provider noted the patient with ongoing chronic low back rated at 7/10 and experiencing anxiety and depression. Exam showed "no significant changes from finding of previous visit." Diagnoses were lumbar spine pain/ radiculitis. The patient received IV Infusion therapy. Reports of 10/8/13 and 12/17/13 again noted unchanged identical symptoms. Objective findings only document vital signs and height/weight (no significant change from previous; however, previous report only documented vital signs) with treatment of IV infusion therapy. Report of 2/18/14 from the provider noted the patient with chronic low back and bilateral knee pain rated at 7/10. Pain is aggravated with prolonged activity of lifting over 5 pounds and with cold weather. Pain is relieved with activity modification, physical therapy, and rest. Request(s) for Physical Therapy to the Lumbar 2 x 4 was partially-certified for quantity #4 on 4/3/14 citing guidelines criteria and lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy to the Lumbar 2 x 4: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy, pages 98-99, Physical Medicine Guidelines -Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2) 8-10 visits over 4 weeks Page(s): 98-99.

Decision rationale: This 54 year-old patient sustained an injury on 6/25/1985 while employed by [REDACTED]. Request(s) under consideration include Physical Therapy to the Lumbar 2 x 4. Diagnoses include lumbar spine pain/ radiculitis. Report of 8/26/13 from the provider noted the patient with ongoing chronic low back rated at 7/10 and experiencing anxiety and depression. Exam showed "no significant changes from finding of previous visit." Diagnoses were lumbar spine pain/ radiculitis. The patient received IV Infusion therapy. Reports of 10/8/13 and 12/17/13 again noted unchanged identical symptoms. Objective findings only document vital signs and height/weight (no significant change from previous; however, previous report only documented vital signs) with treatment of IV infusion therapy. Report of 2/18/14 from the provider noted the patient with chronic low back and bilateral knee pain rated at 7/10. Pain is aggravated with prolonged activity of lifting over 5 pounds and with cold weather. Pain is relieved with activity modification, physical therapy, and rest. Request(s) for Physical Therapy to the Lumbar 2 x 4 was partially-certified for quantity #4 on 4/3/14. Submitted reports have no acute flare-up or specific physical limitations to support for physical therapy. Physical therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. There is unchanged chronic symptom complaints, clinical findings, and work status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. The Chronic Pain Guidelines allow for 9-10 visits of physical therapy with fading of treatment to an independent self-directed home program. The patient has received prior sessions of PT without clear specific functional improvement in ADLs, work status, or decrease in medication and utilization without physiologic evidence of tissue insult, neurological compromise, or red-flag findings to support further treatment. The Physical Therapy to the Lumbar 2 x 4 is not medically necessary and appropriate.