

Case Number:	CM14-0061044		
Date Assigned:	07/09/2014	Date of Injury:	01/10/2007
Decision Date:	09/08/2014	UR Denial Date:	04/16/2014
Priority:	Standard	Application Received:	05/01/2014

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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Texas. 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 73 year old male who sustained an injury to his low back on 01/10/07. The clinical note dated 06/25/14 reported that the injured worker continued to complain of symptoms as being moderate and constant. The injured worker continued to complain of pain across the low back with radiation into the right lower extremity with associated numbness in the foot. The injured worker stated that the pain has also shifted to involve the left buttock with radiation into the groin and anterior thigh all the way down to the knee which occurs mostly at night time. The injured worker noted fair analgesia with his medications without side effects. The injured worker remained independent with his ADLs and attempts to be as active as possible. Physical examination noted femoral stretch normal bilaterally; straight leg raising right radiates left; normal gait; muscle strength and tone normal; spasm absent; paraspinous tenderness; motion elicits pain; Patrick's test negative bilaterally; active painful range of motion; normal bilateral lower extremity strength. The injured worker was diagnosed with lumbosacral disc degeneration, chronic as well as lumbar radiculopathy. His medications were refilled and an epidural steroid injection with physical therapy to address core strengthening was requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

12 Physical therapy visits for the lumbar spine, 2 times a week for 6 weeks, with Physical Therapy Evaluation as an Outpatient: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back chapter, Physical therapy (PT).

Decision rationale: Previous request was denied on the basis that based on the clinical information provided because there was no evidence of radiculopathy or radiculitis on examination. There was no mention that a surgical intervention had been performed or was anticipated. The ODG recommends up to 10 visits over 8 weeks for the diagnosed injury with allowing for fading of treatment frequency (from up to 3 or more visits per week to 1 or less), plus active self-directed home physical therapy. There was no indication that the injured worker is actively participating in a home exercise program. There was no information provided that would indicate the amount of physical therapy visits the injured worker has completed to date or the injured worker's response to any previous conservative treatment. There was no additional significant objective clinical information provided for review that would support the need to exceed the ODG recommendations for physical therapy. The request is not indicated as medically necessary.