

Case Number:	CM14-0069255		
Date Assigned:	07/14/2014	Date of Injury:	04/13/2011
Decision Date:	08/11/2014	UR Denial Date:	05/05/2014
Priority:	Standard	Application Received:	05/14/2014

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 in Neuromuscular Medicine and is licensed to practice in Maryland. 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 55 year old male with a work injury dated 6/1/000. The diagnoses include lumbar facet syndrome, lumbar radiculopathy, low back pain, knee pain, pain in the joint of the lower leg. Under consideration is a request for 6 sessions of physical therapy evaluation and treatment for the lumbar spine, twice a week for three weeks as an outpatient. There is decreased lumbar range of motion, paravertebral tenderness. Lumbar facet loading is positive on the right side. The straight leg raise is negative. The ankle jerk is 0/4 on the right and 2/4 on the left. The patellar jerk is 2/4 on both sides. On There is paravertebral tenderness to palpation. The heel and toe walk are normal. The Gaenslen test is negative. Lumbar facet loading is positive on the right side. The straight leg raise test is negative. Hip range of motion is restricted. The Fabere test is positive. . Internal rotation of the femur resulted in deep buttock pain. The right knee range of motion is restricted with flexion limited to 105 degrees and pain but normal extension. Tenderness to palpation is noted over the lateral joint line and medial joint line. No joint effusion noted. Motor testing is limited by pain. The motor strength of the EHL is 5-/5 on the right and ankle dorsiflexion is 5-/5 on the right. On sensory examination light touch sensation is decreased over lateral calf and lateral thigh. On the right side sensation is decreased over the medial foot, medial calf and lateral calf on the right. On examination of deep tendon reflexes, knee jerk is 2/4 on both sides; ankle jerk is 2/4 on the left side. : Ankle clonus is absent. Babinski's sign is negative. Straight leg raising test is negative. The treatment plan includes spinal cord stimulator; pending authorization for right intraarticular hip injection. The document indicates that the patient completed a transforaminal epidural steroid injection at L5-s1 on the right with only mild improvement in hip pain and radiating right leg pain. The document states that the patient completed 6 PT sessions and there is a re request for 6 additional sessions. Per documentation

the patient was reserving the therapy for after the hip injection but in the interim his symptoms became worse. The patient is to continue modified work duty.

IMR ISSUES, DECISIONS AND RATIONALES

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

6 sessions of physical therapy evaluation and treatment for the lumbar spine, twice a week for three weeks as an outpatient.: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: 6 sessions of physical therapy evaluation and treatment for the lumbar spine, twice a week for three weeks as an outpatient is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The documentation indicates that the patient has already had 6 visits of therapy for his lumbar condition. There are no objective reports from the therapy sessions indicating functional improvement. Furthermore, the patient can have up to 10 visits for this condition. An additional 6 would exceed the recommended guidelines. The request for 6 sessions of physical therapy evaluation and treatment for the lumbar spine, twice a week for three weeks as an outpatient is not medically necessary.