

Case Number:	CM14-0077037		
Date Assigned:	07/18/2014	Date of Injury:	04/30/2010
Decision Date:	09/18/2014	UR Denial Date:	05/21/2014
Priority:	Standard	Application Received:	05/27/2014

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:

The injured worker is a 55-year-old female who reported an injury on 04/30/2010. The mechanism of injury was not provided within the documentation submitted for review. The injured worker's diagnosis was noted to be lumbago. Prior treatment included physical therapy and medications, and the diagnostics include MRI of the lumbar spine. The injured worker had a clinical evaluation on 05/05/2014 with complaints of back pain and right leg pain that radiated to the trochanteric bursitis. The physical exam notes unchanged neurologic status, straight leg signs were unremarkable, and reflexes were +1 at the knees and ankles. Treatment recommendations include an MRI. Medications were noted to be naproxen, Vicodin, and Premarin. A Request for Authorization was found indicating physical therapy; this was request was dated 05/07/2014. The provider's rationale for the request is noted within the review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy 2xWk X 4Wks Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines- Treatment for Workers Compensation, Online Edition Chapter: Low Back- Lumbar & Thoracic Physical Therapy; ODG Physical Therapy Guidelines; ODG Preface.

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

Decision rationale: The California MTUS Chronic Pain Medical Treatment Guidelines recommend 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. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual, and/or tactile instruction. Injured workers are instructed and expected to continue active therapies at home as an extension of the treatment process, in order to maintain improvement levels. Home exercise can include, exercise with or without mechanical assistance or resistance and functional activities with assistive devices. The 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. The guidelines allow 8 to 10 visits over 4 weeks. The clinical evaluation noted the injured worker without functional deficits. Pain was not noted to be significant and uncontrolled. The injured worker has a history of medication management and physical therapy. It is not noted how many physical therapy sessions the injured worker had completed before this request was submitted. Range of motion and strength were not noted to be significantly impaired. Objective functional deficits were not noted. According to the guidelines, the injured worker does not meet the criteria for a medical necessity. Therefore, the request for Physical Therapy 2xWk X 4Wks Lumbar Spine is not medically necessary.