

Case Number:	CM14-0088296		
Date Assigned:	07/23/2014	Date of Injury:	05/02/2006
Decision Date:	10/10/2014	UR Denial Date:	05/13/2014
Priority:	Standard	Application Received:	06/11/2014

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 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 records, presented for review, indicate that this 48-year-old female was reportedly injured on May 2, 2006. The most recent progress note, dated April 18, 2014 indicated that there were ongoing complaints of low back pain. The physical examination demonstrated loss of lumbar lordosis and tenderness over the L4 through S1 paraspinals with palpable spasm. Lumbar spine range of motion was diminished. A positive straight leg raise on the left greater than right produced back pain and leg pain. Diminished strength of the anterior tibiali, and gastrocnemius was noted with diminished sensation to light touch over the L5 and S1 distribution, with a diminished Achilles reflexes bilaterally. Diagnostic imaging studies, noted in the medical record, included an MRI scan of the cervical spine revealing disk desiccation, and loss of cervical lordosis with a disc protrusion at C4-C5, C5-C6 and C6-C7, and C7-T1 with resultant spinal stenosis. EMG and nerve conduction studies of the upper extremities reportedly revealed findings consistent with the left C5 radiculopathy. EMG/NCV studies of the bilateral lower extremities was reportedly without abnormality. An MRI of the lumbar spine revealed disc herniation causing central canal stenosis and bilateral lateral recess stenosis contacting the bilateral L5 transiting nerve roots, with concurrent hypertrophy of the facet joints and ligamentum flavum, with bilateral neural foraminal stenosis contacting the bilateral exiting L4 nerve roots. Previous treatment included bilateral carpal tunnel release procedures, multilevel cervical spine fusion, pharmacotherapy, activity modifications, physical therapy, and lumbar epidural steroid injections at L5-S1. A request had been made for 18 sessions of postoperative physical therapy for the low back and was not certified in the pre-authorization process on May 13, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post operative physical therapy three times a week for six weeks, lower back: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines California Code of Regulations, section 9792.20 et seq. Effective July 18, 2009 (Final Version).

Decision rationale: The records, presented for review, indicate that this 48-year-old female was reportedly injured on May 2, 2006. The most recent progress note, dated April 18, 2014 indicated that there were ongoing complaints of low back pain. The physical examination demonstrated loss of lumbar lordosis and tenderness over the L4 through S1 paraspinals with palpable spasm. Lumbar spine range of motion was diminished. A positive straight leg raise on the left greater than right produced back pain and leg pain. Diminished strength of the anterior tibiali, and gastrocnemius was noted with diminished sensation to light touch over the L5 and S1 distribution, with a diminished Achilles reflexes bilaterally. Diagnostic imaging studies, noted in the medical record, included an MRI scan of the cervical spine revealing disk desiccation, and loss of cervical lordosis with a disc protrusion at C4-C5, C5-C6 and C6-C7, and C7-T1 with resultant spinal stenosis. EMG and nerve conduction studies of the upper extremities reportedly revealed findings consistent with the left C5 radiculopathy. EMG/NCV studies of the bilateral lower extremities was reportedly without abnormality. An MRI of the lumbar spine revealed disc herniation causing central canal stenosis and bilateral lateral recess stenosis contacting the bilateral L5 transiting nerve roots, with concurrent hypertrophy of the facet joints and ligamentum flavum, with bilateral neural foraminal stenosis contacting the bilateral exiting L4 nerve roots. Previous treatment included bilateral carpal tunnel release procedures, multilevel cervical spine fusion, pharmacotherapy, activity modifications, physical therapy, and lumbar epidural steroid injections at L5-S1. A request had been made for 18 sessions of postoperative physical therapy for the low back and was not certified in the pre-authorization process on May 13, 2014.