

Case Number:	CM14-0139872		
Date Assigned:	09/08/2014	Date of Injury:	04/08/2014
Decision Date:	01/30/2015	UR Denial Date:	08/08/2014
Priority:	Standard	Application Received:	08/28/2014

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 Preventive Medicine, has a subspecialty in Occupational Medicine and is licensed to practice in Iowa. 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 patient is a 37 year old employee with date of injury of 4/8/14. Medical records indicate the patient is undergoing treatment for cervical disc syndrome, lumbar disc syndrome, lumbar radiculitis, insomnia, gastroesophageal reflux disease and intractable pain. Subjective complaints include low back and hip pain as well as pain to his neck, chest, upper back and bilateral shins. His low back pain occasionally radiates to his bilateral buttocks. He rates his low back pain as 7/10 and neck pain as 5/10. Objective findings include tenderness to palpation over paraspinal muscles with no noted spasm in the lumbar spine. Lumbar spine range of motion: flexion: 90 degrees; extension and lateral flexion to the left and right are all 25 degrees. The patient has a negative straight leg test. An MRI on June 14, 2014 revealed a L2-L3 3mm left forminal zone disc protrusion. Treatment has consisted of physical therapy, moist heat pad, biofreeze, Cyclobenzaprine, Tramadol, Nabumetone and Omeprazole. The utilization review determination was rendered on 8/8/2014 recommending non-certification of Physical Therapy 16 visits.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy, 16 visits: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315, Chronic Pain Treatment Guidelines Physical Therapy, Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back-Lumbar and Thoracic (Acute and Chronic), Physical Therapy

Decision rationale: California MTUS guidelines refer to physical medicine guidelines for physical therapy and recommends as follows: "Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." Additionally, ACOEM guidelines advise against passive modalities by a therapist unless exercises are to be carried out at home by patient. ODG quantifies its recommendations with 10 visits over 8 weeks for lumbar sprains/strains and 9 visits over 8 weeks for unspecified backache/lumbago. ODG further states that a "six-visit clinical trial" of physical therapy with documented objective and subjective improvements should occur initially before additional sessions are to be warranted. The request is for 16 visits which is in excess of the guideline recommended 10 over 8 weeks. The previous review modified the request to 10 visits to allow for documentation of subjective and objective improvement. As such, the request for Physical therapy 16 visits is not medically necessary.