

Case Number:	CM14-0187677		
Date Assigned:	11/18/2014	Date of Injury:	03/05/2013
Decision Date:	01/06/2015	UR Denial Date:	10/29/2014
Priority:	Standard	Application Received:	11/11/2014

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, has a subspecialty in Pain Medicine 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:

This 62 year old male sustained an industrial related injury on 09/30/2012 of unknown mechanism. The results of the injury included ongoing neck pain and weakness in the right arm and hand. The injured worker was previously diagnosed with right shoulder tendonitis and acromioclavicular (AC) joint arthritis, cervical disc herniation with severe frontal stenosis at C5-C6, C6-C7 and C7-T1, cervical sprain with radicular symptoms, mild left C7-C8 radiculopathy, mild cubital tunnel syndrome, mild right and moderate left carpal tunnel syndrome, severe right C6, C7 and C8 radiculopathy, and status post right carpal tunnel release surgery. There were no new diagnoses documented. Treatment to date has included oral medications and a previous right carpal tunnel release on 10/04/2013. The clinical notes state that an Anterior Cervical Discectomy and Fusion (ACDF) has been authorized, but not completed pending authorization for a new and current MRI. Diagnostic testing has included a note regarding a MRI of the cervical spine on 11/17/2012, but no report was provided. No other testing results were provided or discussed in the clinical notes. According to the PR-2, dated 10/22/2014, subjective complaints included ongoing neck pain, worsening pain and weakness to the right arm and hand, difficulty grasping/gripping objects, low back pain that radiates to the right lower extremity, and numbness and weakness in the right leg. An exam of the thoracolumbar spine revealed left lumbar paraspinal tenderness and decreased range of motion (ROM) with significantly decreased flexion, extension bilateral lateral bending and bilateral rotation. A request for the authorization of physical therapy (PT) was submitted for the treatment of the low back pain. Treatments in place around the time the PT was requested included oral medications. The injured worker's pain and functional deficits were worsened in relation to the low back pain and right lower extremity numbness and weakness. There were no noted changes in activities of daily living. Work functions were unchanged as the injured worker remained on modified work duties. Dependency

on medical care was unchanged. On 10/29/2014, Utilization Review non-certified a prescription for 6 sessions (2 times per week for 3 weeks) of physical therapy (PT) for the lumbar spine, which was requested on 10/22/2014. The physical therapy was non-certified based on insufficient evidence to support PT for the lumbar spine prior to the approved ACDF. The MTUS guidelines - Low Back section was cited. This UR decision was appealed for an Independent Medical Review. The submitted application for Independent Medical Review (IMR) requested an appeal for the non-certification of PT for the lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy to the lumbar: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298, Chronic Pain Treatment Guidelines Page(s): 98 of 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Physical Therapy

Decision rationale: Regarding the request for lumbar spine physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. Official Disability Guidelines (ODG) has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, there is no indication of functional improvement from any previous physical therapy, and there is no statement indicating why an independent program of home exercise would be insufficient to address any objective deficits. Additionally, this is an open ended request with no frequency and duration. As such, the current request for lumbar spine physical therapy is not medically necessary.