MAXIMUS Federal Services

Case Number:	CM14-0194547		
Date Assigned:	12/02/2014	Date of Injury:	12/09/2002
Decision Date:	01/20/2015	UR Denial Date:	11/12/2014
Priority:	Standard	Application Received:	11/19/2014

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 Occupational 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:

The applicant is a represented [redacted] employee who has filed a claim for chronic low back pain reportedly associated with an industrial injury of December 9, 2002. In a Utilization Review Report dated November 12, 2014, the claims administrator failed to approve a request for 12 sessions of physical therapy. The claims administrator did not cite any guidelines in its report rationale but stated at the bottom of the report that its decision was based on non-MTUS Third Edition ACOEM Guidelines. The claims administrator did allude to the applicant's having undergone earlier lumbar fusion surgery on May 21, 2014. In an appeal letter dated November 17, 2014, the applicant's treating provider, a neurosurgeon, stated that the applicant had undergone a single-level L3-L4 lumbar fusion on May 21, 2014. The attending provider stated that the applicant experienced issues with slow recovery/delayed recovery. The attending provider did not outline the applicant's work status. The attending provider appealed the denial of earlier physical therapy and a concomitant denial of the TENS unit. The attending provider also took exception with the claims administrator's failure to incorporate any guidelines into its report rationale. No clinical progress notes were incorporated into the Independent Medical Review packet, which comprised solely of the Utilization Review Report and the attending provider's appeal letter.

IMR ISSUES, DECISIONS AND RATIONALES

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

Twelve additional physical therapy visits, two times a week for six weeks for the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

Decision rationale: The applicant was still within the six-month post-surgical physical medicine treatment period established in the California MTUS Post-Surgical Treatment Guidelines following earlier lumbar spine surgery on May 21, 2014 as of the date of the Request for Authorization (RFA), October 10, 2014. While the MTUS Post-Surgical Treatment Guidelines do support a general course of 34 sessions of post-surgical physical medicine treatment following lumbar fusion surgery as apparently transpired here, this recommendation, however, is qualified by commentary made in MTUS 9792.24.3.c.4 to the effect that the frequency of post-surgical physical medicine treatment shall be gradually reduced or discontinued as an applicant gains independence in management of symptoms and with achievement of functional goals and to the effect that post-surgical treatment shall be discontinued at any time during the post-surgical physical medicine period in applicants in whom no functional improvement is demonstrated. In this case, no clinical progress note was attached to the Request for Authorization. The attending provider's appeal letter did not outline how much cumulative physical therapy treatment had transpired to date, nor did the attending provider clearly outline or delineate what benefits and/or functional gains the applicant had made with prior treatment. The applicant's work and functional status were not, as noted previously, outlined either in the Utilization Review Report or the attending provider's appeal letter. No clinical progress notes were incorporated into the Independent Medical Review packet. However, failed to support or substantiate the request. Therefore, the request was/is not medically necessary.