

Case Number:	CM14-0195908		
Date Assigned:	12/03/2014	Date of Injury:	12/16/2002
Decision Date:	01/23/2015	UR Denial Date:	10/24/2014
Priority:	Standard	Application Received:	11/22/2014

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:

This case involves a 64 year old female was injured on 12/16/2002 while being employed. On physician's progress report for exam date 07/31/2014, the injured worker complained of chronic low back pain. The injured worker had previously received a spinal implant but was noted to cause more pain resulting in it being removed. On assessment, she was noted as having tenderness to palpation in lumbar back area with a decreased range of motion. She was noted to be taking Norco, Skelexin, Ultram and Phenergan medication. On return physician visit dated 10/16/2014, her symptoms continued and noted that the pain in the sciatic area had worsened. Plan of care included previously prescribe medication and physical therapy (PT) 3 x a week for 4 weeks. Per documentation, she previously benefited from physical therapy; however no evidence of measurable function improvement was submitted for review. The Utilization Review dated 10/24/2014, non-certified the request for physical therapy 3 x a week x 4 weeks to the low back as not being medically necessary. The reviewing physician referenced CA MTUS Chronic Pain Treatment Guidelines and Official Disability Guidelines (ODG), Low Back for recommendations.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 3 times a week for 4 weeks to the low back: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Physical Therapy

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58-60.

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines state that 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. Continued physical therapy is predicated upon demonstration of a functional improvement. There is no documentation of objective functional improvement; therefore, this request is not medically necessary.