

Case Number:	CM14-0197708		
Date Assigned:	12/08/2014	Date of Injury:	02/01/1999
Decision Date:	01/16/2015	UR Denial Date:	11/05/2014
Priority:	Standard	Application Received:	11/26/2014

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:

This 59 year-old patient sustained an injury on 2/1/1999 while employed by [REDACTED]. Request(s) under consideration include Physical Therapy, 3 x 4 and LSO brace. Diagnoses include Lumbosacral spondylosis without myelopathy; Lumbago; and Chronic pain syndrome. Conservative care has included medications, therapy, and modified activities/rest. Report of 9/29/14 from the provider noted the patient with low back pain and bilateral lower extremity radiculopathy, numbness and spasm. Current medications list Percocet and Zanaflex. Exam showed unchanged findings of limited cervical range with flexion/extension of 40/50 degrees; pain on compression; lumbar spine with tenderness at paraspinal musculature; limited range of flexion/extension/lateral bending of 55/10/15 R/ 17 L with positive SLR (straight leg raise); muscle spasm and abnormal gait. Treatment included continuing medications, PT, and LSO brace. The request(s) for Physical Therapy, 3 x 4 and LSO (lumbar sacral orthosis) brace were non-certified on 11/5/14 citing guidelines criteria and lack of medical necessity.

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: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy, Physical Medicine Guidelines Page(s): 98-99.

Decision rationale: Physical therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. However, there is no clear measurable evidence of progress with the PT treatment already rendered including milestones of increased ROM (range of motion), strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints, clinical findings, and work status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. The Chronic Pain Guidelines allow for 9-10 visits of physical therapy with fading of treatment to an independent self-directed home program. It appears the employee has received significant therapy sessions without demonstrated evidence of functional improvement to allow for additional therapy treatments. There is no report of acute flare-up, new injuries, or change in symptom or clinical findings to support for formal PT in a patient that has been instructed on a home exercise program for this chronic injury. Submitted reports have not adequately demonstrated the indication to support further physical therapy when prior treatment rendered has not resulted in any functional benefit. The Physical Therapy, 3 times a week for 4 weeks is not medically necessary and appropriate.

LSO brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Lumbar supports

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Back brace

Decision rationale: There are no presented diagnoses of instability, compression fracture, or spondylolisthesis with spinal precautions to warrant a back brace for chronic low back pain. Reports have not adequately demonstrated the medical indication for the LSO. Based on the information provided and the peer-reviewed, nationally recognized guidelines, the request for an LSO cannot be medically recommended. CA MTUS notes lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. This patient is well beyond the acute phase of injury of 2/1/1999. In addition, ODG states that lumbar supports are not recommended for prevention; is under study for treatment of nonspecific LBP (low back pain); and only recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, or post-operative treatment. Submitted reports have not adequately demonstrated indication or support for the request beyond the guidelines recommendations and criteria. The LSO brace is not medically necessary and appropriate.

