

Case Number:	CM14-0201482		
Date Assigned:	12/11/2014	Date of Injury:	02/07/2008
Decision Date:	01/31/2015	UR Denial Date:	10/31/2014
Priority:	Standard	Application Received:	12/01/2014

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 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 patient sustained an injury on 2/7/08 while employed by [REDACTED]. Request(s) under consideration include 12 physical therapy sessions to the left knee, 3 times a week for 4 weeks. Diagnoses include low back pain and lumbar radiculopathy. The patient is s/p T9-10 discectomy via thoracotomy and use of micro-dissection on 12/3/10. Current medications list Norco and Fentanyl patch. Conservative care has included medications, therapy, and modified activities/rest. Report of 6/30/14 noted the patient has had 10 PT visits. Report of 10/29/14 from the provider noted the patient with chronic ongoing back pain rated at 9/10 with 75% frequency. Exam showed unchanged findings of 2-3/5 in dorsiflexion; normal sensation. The request(s) for 12 physical therapy sessions to the left knee, 3 times a week for 4 weeks was partially certified for 4 sessions to transition to a home exercise program on 10/31/14 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 Lower Back: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines Low Back, Physical Therapy

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

Decision rationale: This patient sustained an injury on 2/7/08 while employed by [REDACTED]. Request(s) under consideration include 12 physical therapy sessions to the left knee, 3 times a week for 4 weeks. Diagnoses include low back pain and lumbar radiculopathy. The patient is s/p T9-10 discectomy via thoracotomy and use of micro-dissection on 12/3/10. Current medications list Norco and Fentanyl patch. Conservative care has included medications, therapy, and modified activities/rest. Report of 6/30/14 noted the patient has had 10 physical therapy (PT) visits. Report of 10/29/14 from the provider noted the patient with chronic ongoing back pain rated at 9/10 with 75% frequency. Exam showed unchanged findings of 2-3/5 in dorsiflexion; normal sensation. The request(s) for 12 physical therapy sessions to the left knee, 3 times a week for 4 weeks was partially certified for 4 sessions to transition to a home exercise program on 10/31/14. It has been over 4 years since the micro-dissection discectomy surgical procedure with applicable chronic guidelines. 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 range of motion (ROM), 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 lower back is not medically necessary and appropriate.