

Case Number:	CM14-0207025		
Date Assigned:	12/19/2014	Date of Injury:	02/18/2012
Decision Date:	02/12/2015	UR Denial Date:	11/14/2014
Priority:	Standard	Application Received:	12/10/2014

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 Preventive Medicine, has a subspecialty in Occupational Medicine and is licensed to practice in Iowa. 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 is a 48 year old employee with date of injury of 2/18/12. Medical records indicate the patient is undergoing treatment for major depressive disorder, mild; chronic pain syndrome; lumbosacral spondylosis without myelopathy; degeneration thoracic/lumbar and lumbar/lumbosacraal intervertebral disc; postlaminectomy syndrome lumbar region; thoracic/lumbosacral neuritis/radiculitis unspecified; acquired spondylolisthesis; congenital spondylolysis lumbosacral region and lumbar sprain/strain. The claimant underwent a PLIF on 1/28/14. Subjective complaints include pain rated at 7/10 in the low back which radiates to the mid back. Pain is described as constant, burning, aching, deep pressure, cramping, knifelike, tingling, throbbing, electrical, shooting, stabbing and jabbing. It is moderate to severe. Pain is increased with: activity, cold weather, rest, standing, bending, lifting, turning, twisting, application of ice and general movement. He complains of weakness and numbness. He is depressed and anxious. He says the pain does not allow him to sleep at night. Objective findings include exam of neck reveals: tenderness; extension and flexion are normal with pain; right and left rotation are normal without pain; thoracic spine is abnormal, tender bilaterally; lumbar spine is: tender, stiff, limited range of motion; extension and flexion are decreased with pain and left and right rotation are normal with pain. There is tenderness over: the right sacroiliac joint, bilateral lumbar paraspinal muscles, vertebral at the midline cervical and lumbar region and the bilateral lumbar facets. He uses a walker for assistance and has an unsteady gait. Straight leg test is negative bilaterally. The right and left upper and lower extremities are all painless with full range of motion and no gross abnormalities. CT Scan on 7/22/14 showed a mild facet arthropathy uptake at left L4-5. Treatment has consisted of Metformin, Cymbalta, Meloxicam and a referral to a psychologist. He has a lumbar steroid injection on 9/12/14 which provided relief. The

utilization review determination was rendered on 11/14/14 recommending non-certification of Continued Post Op PT for core and truck stabilization 2x4.

IMR ISSUES, DECISIONS AND RATIONALES

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

Continued Post Op PT for core and truck stabilization 2x4: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98 and 99. Decision based on Non-MTUS Citation ODG-TWC, Low Back Procedure Summary

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315, Chronic Pain Treatment Guidelines Physical Therapy, Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Physical Therapy.

Decision rationale: California MTUS guidelines refer to physical medicine guidelines for physical therapy and recommends as follows: "Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." Additionally, ACOEM guidelines advise against passive modalities by a therapist unless exercises are to be carried out at home by patient. ODG quantifies its recommendations: Post-surgical treatment (fusion, after graft maturity): 34 visits over 16 weeks. ODG further states that a "six-visit clinical trial" of physical therapy with documented objective and subjective improvements should occur initially before additional sessions are to be warranted. Medical records indicate that patient has completed an unknown number of physical therapy visits and the treating physician did not provide documentation of objective and subjective improvements. As such, the request for Continued Post Op PT for core and truck stabilization 2x4 is not medically necessary.