MAXIMUS Federal Services

Case Number:	CM15-0140066		
Date Assigned:	07/29/2015	Date of Injury:	06/06/2000
Decision Date:	08/27/2015	UR Denial Date:	07/06/2015
Priority:	Standard	Application Received:	07/20/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: California
Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 injured worker is a 72 year old female, who sustained an industrial injury on 6-6-2000. The mechanism of injury is unknown. The injured worker was diagnosed as having left lumbar 3 radiculopathy with herniated disc at lumbar 3-4, disc bulge at lumbar 4-5 and disc protrusion at lumbar 5-sacal 1. There is no record of a recent diagnostic study. Treatment to date has included lumbar radiofrequency ablation, epidural steroid injections, therapy and medication management. In a progress note dated 6-17-2015, the injured worker complains of low back pain rated 5-7 out of 10. Physical examination showed tenderness to palpation in the left greater than right paralumbar muscles. The treating physician is requesting 6 sessions of physical therapy for post-injection rehabilitation for the lumbar spine and Botox injection 300 units for the lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy x 6 for the Lumbar Spine: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298, Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98 of 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Physical Therapy.

Decision rationale: Regarding the request for additional physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, there is documentation of completion of prior PT sessions, but there is no documentation of specific objective functional improvement with the previous sessions and remaining deficits that cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised therapy. Additionally, it appears the therapy is being requested in conjunction with Botox injections. The Botox injections are not medically necessary; therefore post-injection therapy is not medically necessary. As such, the currently requested additional physical therapy is not medically necessary.

Botox Injection 300 Units x 1 for the Lumbar Spine: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Botulinum Toxin Page(s): 25-26 of 127. Decision based on Non-MTUS Citation (ODG) Low Back Chapter, Botox.

Decision rationale: Regarding the request for Botox for treatment of low back pain, Chronic Pain Medical Treatment Guidelines state that Botox may be considered in conjunction with a functional restoration program. ODG also states that it should be used in conjunction with a functional restoration program and reserved for patients with pain refractory to other invasive treatments. Within the documentation available for review, there is no indication that the patient is involved in a functional restoration program. Six therapy sessions do not constitute a functional restoration program. As such, the currently requested Botox injections for the low back are not medically necessary.