

Case Number:	CM15-0142579		
Date Assigned:	08/03/2015	Date of Injury:	07/26/1999
Decision Date:	08/31/2015	UR Denial Date:	06/30/2015
Priority:	Standard	Application Received:	07/22/2015

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 76 year old male with an industrial injury dated 07-26-1999. The injured worker's diagnoses include benign neoplasm of pituitary gland and craniopharyngeal duct, chronic pain syndrome, degeneration of lumbar or lumbosacral intervertebral disc, unspecified thoracic or lumbosacral neuritis or radiculitis, adjustment disorder with mixed anxiety & depressed mood, unspecified disorder of muscle, ligament and fascia, cervicgia, and enthesopathy of hip region. Treatment consisted of diagnostic studies, prescribed medications, pain pump and periodic follow up visits. In a progress note dated 06-19-2015, the injured worker reported increase acute right hip pain, low back pain and psychosocial complaint. Objective findings revealed tenderness to palpitation of right lower dorsal and upper lumbar and very limited range of motion. The treating physician prescribed services for eighteen physical therapy sessions, 2-3 times a week for 6 weeks, for low back pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

18 physical therapy for lumbar area 2-3 times a week for 6 weeks for low back pain:

Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99 of 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Physical Medicine.

Decision rationale: Regarding the request for physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course (10 sessions) 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 no documentation of specific objective functional improvement with any 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. Furthermore, the request exceeds the amount of PT recommended by the CA MTUS and, unfortunately, there is no provision for modification of the current request. In light of the above issues, the currently requested physical therapy is not medically necessary.