

Case Number:	CM15-0160558		
Date Assigned:	09/21/2015	Date of Injury:	04/03/2005
Decision Date:	10/22/2015	UR Denial Date:	07/17/2015
Priority:	Standard	Application Received:	08/17/2015

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

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 injured worker is a 43 year old male, who sustained an industrial injury on 04-03-2005. The injured worker was diagnosed as having lumbar degenerative disc disease. On medical records dated 07-07-2015, 06-02-2015 and 04-21-2015, subjective complaints were noted as lower back pain, pain was rated at 4-5 out of 10. Pain was described as dull, achy and pressure. Objective findings were noted as numbness-tingling in the bilateral lower extremities, decreased deep tendon reflexes and tenderness in lower back with palpation. The injured worker underwent a bilateral lower extremity electromyogram and nerve conduction velocity on 05-05-2015 which revealed an evidence of left peroneal and right tibial neuropathy. Treatments to date included medication, spinal cord stimulator and laboratory studies. Current medication was listed not listed on above mentioned medical records dates. The Utilization Review (UR) was dated 07-17-2015. A Request for Authorization was dated 07-09-2015 requested Neurontin, Oxycodone and physical therapy. The UR submitted for this medical review indicated that the request for physical therapy to the lumbar spine 2 times a week for 6 weeks was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy to the lumbar spine 2 times a week for 6 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

Decision rationale: Time-limited care plan with specific defined goals, assessment of functional benefit with modification of ongoing treatment based upon the patient's progress in meeting those goals and the provider's continued monitoring of successful outcome is stressed by MTUS guidelines. 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. Submitted reports have no acute flare-up or specific physical limitations to support for physical/occupational therapy. The Chronic Pain Guidelines allow for 9-10 visits of therapy with fading of treatment to an independent self-directed home program. It is unclear how many PT sessions have been completed; however, the submitted reports have not identified clear specific functional improvement in ADLs, functional status, or decrease in medication and medical utilization nor have there been a change in neurological compromise or red-flag findings demonstrated from the formal physical therapy already rendered to support further treatment for this 2005 injury. Submitted reports have also not adequately demonstrated the indication to support for excessive quantity of PT sessions without extenuating circumstances established beyond the guidelines. The Physical therapy to the lumbar spine 2 times a week for 6 weeks is not medically necessary or appropriate.