

Case Number:	CM15-0162699		
Date Assigned:	09/08/2015	Date of Injury:	12/28/2010
Decision Date:	10/13/2015	UR Denial Date:	07/30/2015
Priority:	Standard	Application Received:	08/19/2015

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, Texas, Florida

Certification(s)/Specialty: Anesthesiology, Pain Management, Hospice & Palliative Medicine

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 68 year old male, who sustained an industrial injury on 12-28-10. He has reported initial complaints of immediate neck, back and right arm pain after a fall. The diagnoses have included lumbar spondylosis without myelopathy, lumbar degenerative disc disease (DDD), lumbar radiculopathy, lumbar herniated disc, lumbar spinal stenosis and lumbago. Treatment to date has included medications, sling, activity modifications, diagnostics, lumbar rhizotomy, injections, 12 sessions of chiropractic and other modalities. The current medications included Tramadol, Gabapentin, and Percocet. He states that the Percocet relieves the pain and decreases it by 50-60 percent and makes it easier to perform his activities of daily living (ADL). The diagnostic testing that was performed included Magnetic Resonance Imaging (MRI) of the lumbar spine. Currently, as per the physician progress note dated 6-19-15, the injured worker complains of neck and low back complaints. In regard to the back he reports aching, burning and stabbing pain that radiates down the right lower extremity (RLE). He also reports cramping in the right lower extremity (RLE) since getting the rhizotomy on 5-22-15. He also reports numbness and tingling in the right calf. The pain is rated 6-7 out of 10 on the pain scale. The right leg pain is rated 6 out of 10 on the pain scale. The injured worker reports that he is not currently working and has not worked since 7-9-12. The objective findings-physical exam reveals that there is tenderness to palpation along the right side middle lumbar paraspinal muscle and along the bilateral mid to lower lumbar paraspinal muscle and active lumbar flexion is limited to 90 degrees secondary to pain. The physician requested treatment included Physical Therapy 2 times a Week for 6 Weeks 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 2xWk x 6Wks for the Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic (Acute & Chronic), Physical Therapy (PT).

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): General Approach, Initial Assessment, Physical Examination, Initial Care, Physical Methods, and Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Physical Therapy.

Decision rationale: Regarding the request for Physical Therapy 2xWk x 6Wks for the Lumbar Spine, 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 no indication of any specific objective treatment goals and no statement indicating why an independent program of home exercise would be insufficient to address any objective deficits. There is documentation of completion of prior chiropractic sessions and 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. 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 the absence of such documentation, the current request for Physical Therapy 2xWk x 6Wks for the Lumbar Spine is not medically necessary.