

Case Number:	CM15-0182646		
Date Assigned:	09/23/2015	Date of Injury:	07/16/2014
Decision Date:	10/28/2015	UR Denial Date:	09/14/2015
Priority:	Standard	Application Received:	09/16/2015

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: Massachusetts

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 54-year-old female, who sustained an industrial injury on 7-16-2014. The injured worker is undergoing treatment for spondylolisthesis, spinal stenosis, post laminectomy, and kyphosis. Dates of service reviewed included 9-23-2014 to 9-24-2015. On 7-14-15, her pain is rated 5 out of 10. The provider noted, "She had failed conservative treatment, PT (physical therapy), cannot sit or stand, walk for 10-15 minutes without severe pain". On 8-19-2015, she reported low back pain with radiation to the right thigh and occasional radiation down to the calf and foot. Physical findings revealed tenderness, no scoliosis, and thoracolumbar kyphosis, and flat back syndrome, abnormal range of motion and muscle spasm in the low back. On 9-24-2015, no subjective findings are documented. Objective findings reported do not demonstrate significant changes from previous examination. The treatment and diagnostic testing to date has included: magnetic resonance imaging of the lumbar spine (9-22-14) reported as revealing spinal stenosis, grade I retrolisthesis L3-4, medications, previous physical therapy (completed amount unclear) reported as failed, magnetic resonance imaging of the lumbar spine (9-23-14). Medications have included Hydrocodone-acetaminophen, Gabapentin, Carisoprodol, Ciprofloxacin, Flector patch, Ibuprofen, Omeprazole, Voltaren gel, and Oxycontin. Current work status: not documented. The request for authorization is for physical therapy two times weekly for 6 weeks for the lumbar spine. The UR dated 9-14-2015: non-certified the request for physical therapy two times weekly 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 2 times per week for 6 weeks to the lumbar spine: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (1) Chronic pain, Physical medicine treatment. (2) Preface, Physical Therapy Guidelines.

Decision rationale: The claimant sustained a work injury in July 2014 and continues to be treated for low back pain with bilateral lumbar radicular symptoms. Her injury occurred when she was trying to move a table while cleaning an animal shelter treatment room. In January 2015 the requesting provider saw her as a new patient. She had a remote history of an L1/2 fracture and had undergone a lumbar fusion with subsequent hardware removal. She was seen after having tried physical therapy and an epidural injection. Lumbar spine fusion surgery with decompression was recommended. She underwent a lumbar epidural injection in August 2015 with 50% improvement, which was temporary. A surgical reevaluation was recommended. She was seen for this on 08/19/15. The previously requested surgery had been denied. She was having severe lumbar pain radiating to the right thigh and occasionally to the calf and foot. Physical examination findings included lumbar tenderness with decreased and painful lumbar spine range of motion with muscle spasms. There was decreased right lower extremity strength. Her reflex responses were symmetrical. Authorization was requested for additional physical therapy. The claimant is being treated for chronic pain with no new injury and has already had physical therapy. Patients are expected to continue active therapies at home. Compliance with a home exercise program would be expected and would not require continued skilled physical therapy oversight. A home exercise program could be performed as often as needed/appropriate rather than during scheduled therapy visits. In terms of physical therapy treatment for chronic pain, guidelines recommend a six visit clinical trial with a formal reassessment prior to continuing therapy. In this case, the number of visits requested is in excess of that recommended or what might be needed to reestablish or revise the claimant's home exercise program. The request is not medically necessary.