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| Case Number: | CM15-0184412 | | |
| Date Assigned: | 09/24/2015 | Date of Injury: | 08/26/1998 |
| Decision Date: | 11/06/2015 | UR Denial Date: | 08/28/2015 |
| Priority: | Standard | Application Received: | 09/18/2015 |

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:

The injured worker is a 63 year old male, who sustained an industrial injury on 8-26-98. The injured worker is undergoing treatment for lumbar herniated nucleus pulposus (HNP) with radiculopathy, lumbar foraminotomy and decompression, left shoulder impingement with rotator cuff tendonitis and left knee meniscus degeneration with sprain-strain. Medical records dated 8-12-15 indicate the injured worker complains of sharp stabbing low back pain radiating to lower extremities with numbness and tingling. He also reports left knee and left shoulder pain described as dull and achy. Office visit dated 4-8-15 indicates, "the patient has been authorized for physical therapy and he will complete them as prescribed and recommended." Physical exam dated 8-12-15 notes decreased lumbar range of motion (ROM) with positive straight leg raise and Kemp's test on the right. There is left shoulder tenderness to palpation with decreased range of motion (ROM) and positive Apley, decompression and rotator cuff tendonitis. There is left knee tenderness to palpation and positive Apley sign and positive grind. Treatment to date has included chiropractic treatment, physical therapy, surgery and medication. The original utilization review dated 8-26-15 indicates the request for eight sessions of physical therapy 2 times a week for 4 weeks for the lumbar spine is non-certified noting lack of evidence in the notes reviewed that there has been a positive outcome with previous sessions of physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Eight sessions of physical therapy 2 times a week for 4 weeks for the lumbar spine:

Overtured

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: The patient presents on 08/12/15 with lower back pain, which radiates into the bilateral lower extremities, left knee pain, and left shoulder pain. The patient's date of injury is 08/26/98. Patient is status post lumbar foraminotomy and decompression surgery on 05/13/13. The request is for eight sessions of physical therapy 2 times a week for 4 weeks for the lumbar spine. The RFA is dated 08/12/15. Physical examination dated 08/12/15 reveals positive straight leg raise and Kemp's tests on the right, tenderness to palpation of the left AC joint with limited range of motion on abduction and adduction. The provider also notes tenderness to palpation of the left pre-patellar region, positive Apley's sign, positive patellar grinding sign, and positive Apley's scratch test, shoulder decompression test, and rotator cuff tendonitis in the left shoulder. The patient's current medication regimen is not provided. Patient is currently classified as permanent and stationary, is not working. MTUS Guidelines, Physical Medicine Section, pages 98, 99 has the following: "recommended as indicated below. Allow for fading of treatment frequency -from up to 3 visits per week to 1 or less-, plus active self-directed home Physical Medicine." MTUS guidelines pages 98, 99 states that for "Myalgia and myositis, 9-10 visits are recommended over 8 weeks. For Neuralgia, neuritis, and radiculitis, 8-10 visits are recommended." In regard to the 8 sessions of physical therapy sessions for the lumbar spine, the request is appropriate. The documentation provided indicates that this patient was approved a course of physical therapy per 04/08/15 progress note, however a careful review of the documentation reveals no evidence that these sessions were carried out and the authorization has since expired. MTUS guidelines support physical therapy as a conservative option for complaints of this nature, up to 10 visits. The request for 8 sessions falls within these recommendations and is an appropriate measure, which could produce benefits for this patient. Therefore, the request IS medically necessary.