

Case Number:	CM15-0186360		
Date Assigned:	09/28/2015	Date of Injury:	07/09/2013
Decision Date:	11/03/2015	UR Denial Date:	08/26/2015
Priority:	Standard	Application Received:	09/22/2015

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

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 56 year old female, who sustained an industrial injury on 7-09-2013. The injured worker was diagnosed as having low back pain, lumbar spine sprain/strain, rule out herniated nucleus pulposus, lumbar radiculopathy, and right hip sprain/strain, rule out internal derangement. Treatment to date has included diagnostics, acupuncture, unspecified physical therapy, and medications. Currently (7-15-2015), the injured worker complains of burning radicular neck pain and muscle spasms, greater on the right (rated 6-7 out of 10, 7 out of 10 on 6-10-2015), burning right shoulder, elbow and wrist pain and muscle spasms (rated 6-7 out of 10, 7 out of 10 on 6-10-2015), burning radicular low back pain and muscle spasms, described as constant and moderate to severe and associated with numbness and tingling of the bilateral lower extremities (rated 6-7 out of 10, 7 out of 10 on 6-10-2015). Her low back pain was aggravated by prolonged positioning, bending and arising from a seated position, ascending or descending stairs, stooping, and activities of daily living, such as getting dressed and performing personal hygiene (unchanged from previous exam). She also reported burning right hip pain and muscle spasms (rated 6 out of 10, 6 out of 10 on 6-10-2015) and burning bilateral knee pain (rated 7 out of 10, 6 out of 10 on 6-10-2015). Exam of the lumbar spine was unchanged from previous exam and noted tenderness to palpation over the spinous processes L4-S1 on the right, along with posterior superior iliac spine and sciatic notch tenderness with spasms on the right. Range of motion was decreased. Exam of the right hip noted tenderness to palpation of the right trochanter and range of motion within normal limits. Neurological exam noted "slightly decreased" sensation at the L4, L5, and S1 dermatomes bilaterally, motor strength 4 of 5 in all the represented muscle groups in the bilateral lower extremities, and vascular pulses were 2+ and symmetrical. She was to continue medications for pain, noting Depriazine, Dicopanol, Fanatrex,

Synapryn, Tabradol, Cyclobenzaprine, Ketoprofen, Capsaicin, Flurbiprofen, Menthol, and Gabapentin. Her work status was total temporary disability. Progress notes from prior physical therapy sessions were not submitted. The amount of prior sessions, dates, and-or benefit (if any) was not noted. The treatment plan included physical therapy, 2x4, for the lumbar spine, non-certified by Utilization Review on 8-26-2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 2 times a week for 4 weeks for the lumbar spine: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: Physical 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. However, there is no clear measurable evidence of progress with the PT treatment already rendered including milestones of increased ROM, strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints, clinical findings, and functional status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. The Chronic Pain Guidelines allow for visits of physical therapy with fading of treatment to an independent self-directed home program. It appears the employee has received significant therapy sessions without demonstrated evidence of functional improvement to allow for additional therapy treatments. There is no report of acute flare-up, new injuries, or change in symptom or clinical findings to support for formal PT in a patient that has been instructed on a home exercise program for this chronic 2013 injury. Submitted reports have not adequately demonstrated the indication to support further physical therapy when prior treatment rendered has not resulted in any functional benefit. The physical therapy 2 times a week for 4 weeks for the lumbar spine is not medically necessary and appropriate.