

Case Number:	CM15-0186443		
Date Assigned:	09/28/2015	Date of Injury:	03/04/2015
Decision Date:	11/06/2015	UR Denial Date:	09/18/2015
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 40 year old male, who sustained an industrial-work injury on 3-4-15. A review of the medical records indicates that the injured worker is undergoing treatment for lumbar strain, lumbar radiculopathy, left trochanteric bursitis, and lumbar disc protrusion with annular tear. Medical records dated (6-18-15 to 9-3-15) indicate that the injured worker complains of continued left lumbosacral back pain that radiates to the left buttocks. The pain also increases with movement, activity and activities of daily living (ADL). There is also a hot sensation of pain in the left lumbosacral region associated with spasm. Per the treating physician report dated 9-3-15 the work status is modified with restrictions. The physical exam dated 9-3-15 reveals that the lumbar spine exam shows that the lumbar range of motion is moderately restricted with pain at the limits of his range. Treatment to date has included pain medication including Mobic, diagnostics, work modifications, physical therapy at least 13 sessions with some pain relief, and other modalities. The physician indicates that the Magnetic resonance imaging (MRI) of the lumbar spine dated 3-23-15 reveals a "left foraminal disc protrusion with annular tear. The physician indicates that the injured worker reports that he was told that the herniation was at L2-3 level and the physician notes that he does not see a significant disc protrusion at L2-3. " The Magnetic Resonance Imaging (MRI) of the lumbar spine dated 3-23-15 reveals L4-5 facet arthropathy and L2-3 left foraminal protrusion, stenosis and without nerve impingement. The request for authorization date was 9-15-15 and requested service included Additional outpatient Physical Therapy, twice a week for six weeks, to the lumbar spine. The original Utilization review dated 9-18-15 non-certified the request for Additional outpatient Physical Therapy, twice a week for six weeks, to the lumbar spine as not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional outpatient Physical Therapy, twice a week for six weeks, to the lumbar spine:
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: 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 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 Guidelines allow for visits of physical therapy with fading of treatment to an independent self-directed home program. It appears the employee has received previous 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 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 Additional outpatient Physical Therapy, twice a week for six weeks, to the lumbar spine is not medically necessary and appropriate.