

Case Number:	CM15-0191306		
Date Assigned:	10/05/2015	Date of Injury:	12/13/2010
Decision Date:	11/12/2015	UR Denial Date:	09/22/2015
Priority:	Standard	Application Received:	09/29/2015

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 52 year old female, who sustained an industrial injury on 12-13-10. She is diagnosed with lumbar disc displacement. Disability status is permanent and stationary. A note dated 7-9-15 - 8-24-15 reveals the injured worker presented with complaints of ongoing low back pain that radiates down her right leg and is rated at 7 out of 10. A physical examination dated 7-9-15 - 8-25-15 revealed lumbar range of motion is restricted and causes pain. There is guarding with motion and hyperextension of the lower back causes radiating pain to her buttocks bilaterally. Muscle spasms are present. Straight leg raise is negative bilaterally and lower extremity muscle strength is within normal limits bilaterally. Treatment to date has included anterior-posterior fusion at level L4-L5 and L5-S1 and medication. A lumbar MRI (6-24-15) reveals evidence of disc desiccation at the level of L3-L4, per physician note dated 8-25-15. A request for authorization dated 9-17-15 for physical therapy for the lumbar spine 2 times a week for 6 weeks is non-certified, per Utilization Review letter dated 9-22-15.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy for the lumbar, twice a week for six weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment 2009.

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

Decision rationale: Time-limited care plan with specific defined goals, assessment of functional benefit with modification of ongoing treatment based upon the patient's progress in meeting those goals and the provider's continued monitoring of successful outcome is stressed by MTUS guidelines. 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. Submitted reports have no acute flare-up or specific physical limitations to support for physical/ occupational therapy. The Chronic Pain Guidelines allow for 9-10 visits of therapy with fading of treatment to an independent self-directed home program. It is unclear how many PT sessions have been completed; however, the submitted reports have not identified clear specific functional improvement in ADLs, functional status, or decrease in medication and medical utilization nor have there been a change in neurological compromise or red-flag findings demonstrated from the formal physical therapy already rendered to support further treatment for this chronic 2010 P&S injury. Submitted reports have also not adequately demonstrated the indication to support for excessive quantity of PT sessions without extenuating circumstances established beyond the guidelines. The Physical Therapy for the lumbar, twice a week for six weeks is not medically necessary and appropriate.