

Case Number:	CM15-0193406		
Date Assigned:	10/07/2015	Date of Injury:	05/17/2008
Decision Date:	11/17/2015	UR Denial Date:	09/10/2015
Priority:	Standard	Application Received:	10/01/2015

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, Indiana, New York
Certification(s)/Specialty: Internal Medicine

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 45 year old female, who sustained an industrial injury on 5-17-2008. The injured worker is undergoing treatment for: lumbar disc herniation with spinal stenosis and radiculopathy. On 9-2-15, she reported low back pain with numbness; tingling and weakness rated 4-6 out of 10. She also reported pain radiation into the bilateral lower extremities with right worse than left and numbness and tingling in both legs. Objective findings revealed tenderness in the sacroiliac joint on the right, decreased lumbar range of motion, normal gait, positive straight leg raise testing on the right, and diminished sensation in the right L5 and S1 nerve roots. The treatment and diagnostic testing to date has included: lumbar surgery (7-28-12), repeat lumbar surgery (1-3-14), medications, completed at least 8 physical therapy sessions with noted improvement of function and decrease in cramping, magnetic resonance imaging of the lumbar spine (December 2013). Medications have included: Gabapentin, Relafen, and Prilosec. Current work status: permanent and stationary. The request for authorization is for: physical therapy for the lumbar spine two times a week for 3 weeks. The UR dated 9-10-2015: non-certified the request for physical therapy for the lumbar spine two times a week for 3 weeks.

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 3 weeks for the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS General Approaches 2004, and Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back section, Physical therapy.

Decision rationale: Pursuant and to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, physical therapy two times per week times three weeks to the lumbar spine is not medically necessary. Patients should be formally assessed after a six visit clinical trial to see if the patient is moving in a positive direction, no direction or negative direction (prior to continuing with physical therapy). When treatment duration and/or number of visits exceed the guideline, exceptional factors should be noted. In this case, the injured worker's working diagnoses are large recurrent disc herniation L4 - L5 with severe spinal stenosis and radiculopathy; status post repeats microdiscectomy L4 - L5 January 2014. Date of injury is May 17, 2008. Request authorization is September 3, 2015. According to a September 2, 2015 progress note, the injured worker status post L4 - L5 back surgery in 2012 and repeat microdiscectomy L4 - L5. The documentation indicates the injured worker received eight out of eight physical therapy sessions with subjective improvement. There is decreased cramping. Subjective complaints include ongoing low back pain with numbness, tingling and weakness. Pain score is 6/10. Objectively, there is decreased range of motion with positive straight leg raising on the right. Motor function is normal. The documentation shows the injured worker completed eight out of eight physical therapy sessions. Based on prior surgeries, it would appear the injured worker had additional physical therapy to date. The total number of physical therapy sessions is not specified. There is no documentation demonstrating objective optional improvement. There are no compelling clinical facts indicating additional physical therapy is clinically indicated. Based on the clinical information in the medical record, peer-reviewed evidence-based guidelines, no documentation indicating the total number of physical therapy sessions to date, no documentation demonstrating objective functional improvement and no compelling clinical facts indicating additional physical therapy is clinically warranted, physical therapy two times per week times three weeks to the lumbar spine is not medically necessary.