

Case Number:	CM15-0196216		
Date Assigned:	10/12/2015	Date of Injury:	07/13/2011
Decision Date:	11/19/2015	UR Denial Date:	10/01/2015
Priority:	Standard	Application Received:	10/07/2015

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: Emergency 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 38 year old female, who sustained an industrial injury on 7-13-11. The injured worker has complaints of low back and upper extremities pain. The documentation noted that the pain is primarily in the low back and lower extremities bilaterally, radicular with sensations of numbness and tingling. The injured worker states the pain is relatively constant with intermittent flares throughout the day and the pain is described as cramping, sharp and shooting in natures with sensations of numbness and tingling and urinary retention. The injured workers visual analog scale is a 1 to 8 out of 10, it is better with medications and relaxation as well as massage, ice and postural changes. Lumbar spine examination revealed decreased range of motion with regard to forward flexion and lumbar extension. Cervical spine examination revealed tenderness to palpation over the bilateral cervicobrachial spine. The diagnoses have included failed back surgery syndrome; lumbar degenerative disc disease; lumbar radiculopathy; cervical spine pain and neck pain and upper extremity radiculopathy. Magnetic resonance imaging (MRI) of the cervical spine on 7-22-14 demonstrated at C5-C6 there is disc desiccation, mild loss of posterior intervertebral disc height, 3-millimeter central and left paracentral posterior disc protrusion with right paracentral extrusion indenting the thecal sac and slightly impinging the left anterior spinal cord. Magnetic resonance imaging (MRI) of the lumbosacral spine on 7-22-14 demonstrated at L5-S1 (sacroiliac) there is disc desiccation, loss of posterior intervertebral disc height, 5 millimeter central disc protrusion with bilateral paracentral extrusion and bilateral foraminal extension abutting the right S1 (sacroiliac) nerve root in the right lateral recess and slightly impinging the left S1 (sacroiliac) nerve root; there is mild-moderate right

lateral recess stenosis; mild left neuroforaminal stenosis and post-surgical changes noted in the low back at L4-L5. Treatment to date has included lumbar laminectomy in 2013; carpal tunnel release in 2014; epidural injection; spinal cord stimulator trial; acupuncture; biofeedback; aquatic therapy; psychotherapy; opiate analgesics and anti-inflammatory medications. The original utilization review (10-1-15) non-certified the request for physical therapy three times a week for four weeks for the lumbar spine, quantity, 12 sessions.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy three times a week for four weeks for the lumbar spine, quantity: 12 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS General Approaches 2004, Section(s): Initial Approaches to Treatment.

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

Decision rationale: The requested Physical therapy three times a week for four weeks for the lumbar spine, quantity: 12 sessions, is not medically necessary. CA MTUS 2009, Chronic Pain Medical Treatment Guidelines, Physical Medicine, Page 98-99, recommend continued physical therapy with documented objective evidence of derived functional improvement. The injured worker has low back and upper extremities pain. The documentation noted that the pain is primarily in the low back and lower extremities bilaterally, radicular with sensations of numbness and tingling. The injured worker states the pain is relatively constant with intermittent flares throughout the day and the pain is described as cramping, sharp and shooting in natures with sensations of numbness and tingling and urinary retention. The injured workers visual analog scale is a 1 to 8 out of 10, it is better with medications and relaxation as well as massage, ice and postural changes. Lumbar spine examination revealed decreased range of motion with regard to forward flexion and lumbar extension. The treating physician has not documented objective evidence of derived functional improvement from completed physical therapy sessions, nor the medical necessity for additional physical therapy to accomplish a transition to a dynamic home exercise program. The criteria noted above not having been met, Physical therapy three times a week for four weeks for the lumbar spine, quantity: 12 sessions is not medically necessary.