

Case Number:	CM15-0197939		
Date Assigned:	10/13/2015	Date of Injury:	08/07/2013
Decision Date:	11/20/2015	UR Denial Date:	09/29/2015
Priority:	Standard	Application Received:	10/08/2015

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 44 year old male who sustained an industrial injury on 08-07-2013. A review of the medical records indicated that the injured worker is undergoing treatment for lumbar degenerative disc disease, lumbago, neck sprain and strain, cervicalgia and unspecified mood disorder. According to the treating physician's progress report on 09-21-2015, the injured worker continues to experience neck and low back pain. Examination demonstrated diffuse tenderness from the cervical spine through the lumbar spine. There was full range of motion of the lumbar spine causing pain in the paralumbar areas. Seated straight leg raise caused pain in the back and buttocks extending down both legs. Internal and external rotation of the hips elicited pain in the lower back. The cervical spine examination demonstrated mid to lower paracervical and periscapular tenderness to palpation with aggravated pain with extension of the cervical spine. Range of motion was reduced by 50% in right rotation and 75% of the expected range of motion with rotation to the left. Waddell's signs were positive for axial loading. Motor strength and sensation were intact in the bilateral upper and lower extremities. Deep tendon reflexes were 2 out of 4 in the biceps, triceps and brachioradialis. Patellar reflexes were noted at 1 out of 4 and trace in the Achilles bilaterally. Prior treatments have included diagnostic testing, physical therapy (6 sessions), psychiatric evaluation and medications. Current medications were listed as Norco, Diclofenac and Venlafaxine. Treatment plan consists of cognitive behavioral therapy (CBT) for 6 visits and the current request for physical therapy twice a week for 4 weeks. On 09-29-2015 the Utilization Review modified the request for physical therapy twice a week for 4 weeks to physical therapy for 3 sessions to assess and facilitate a home exercise program.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 2 times per week for 4 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Physical Therapy Guidelines http://www.odg-twc.com/odgtwc/Low_Back.htm.

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

Decision rationale: Review indicates the request for PT was modified for 3 sessions to facilitate the transfer to an independent home exercise program. 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 per week for 4 weeks is not medically necessary or appropriate.