

Case Number:	CM15-0198207		
Date Assigned:	10/13/2015	Date of Injury:	09/28/2014
Decision Date:	11/23/2015	UR Denial Date:	09/10/2015
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: 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 40 year old female with an industrial injury date of 09-28-2014. Medical record review indicates she is being treated for strain-acute lumbosacral, strain-thoracic spine and strain left posterior trapezius. Subjective complaints (11-07-2014) included pain in the low back without radiation. The injured worker stated she felt about the same as last visit. The treating physician documented no medication side effects. "The patient states she is performing modified work duties safely without any problems or worsening symptoms." Prior treatment included physical therapy (number of visits not indicated). Physical exam (11-07-2014) noted normal gait. There was tenderness to the left paralumbosacral area. Straight leg raising was negative bilaterally. The treating physician noted physical therapy "will be requested to accelerate functional improvement." On 09-10-2015 the request for retro: physical therapy x 2 lumbar DOS: 12/29/2014 and 12/30/2014 was non-certified by utilization review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro: physical therapy x2 lumbar DOS: 12/29/2014 and 12/30/2014: Upheld

Claims Administrator guideline: Decision based on MTUS 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 rationale: The requested Retro: physical therapy x2 lumbar DOS: 12/29/2014 and 12/30/2014, is not medically necessary. CA MTUS 2009, Chronic Pain Medical Treatment Guidelines, Physical Medicine, pages 98 and 99, recommend continued physical therapy with documented objective evidence of derived functional improvement. The injured worker has pain in the low back without radiation. The injured worker stated she felt about the same as last visit. The treating physician documented no medication side effects. The patient states she is performing modified work duties safely without any problems or worsening symptoms. Prior treatment included physical therapy (number of visits not indicated). Physical exam (11-07-2014) noted normal gait. There was tenderness to the left paralumbosacral area. Straight leg raising was negative bilaterally. The treating physician noted physical therapy "will be requested to accelerate functional improvement." 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, Retro Physical Therapy x2 lumbar DOS: 12/29/2014 and 12/30/2014 is not medically necessary.