

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM15-0200646 | | |
| Date Assigned: | 10/15/2015 | Date of Injury: | 11/15/2005 |
| Decision Date: | 12/02/2015 | UR Denial Date: | 09/18/2015 |
| Priority: | Standard | Application Received: | 10/13/2015 |

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 51 year old male, who sustained an industrial injury on 11-15-05. The injured worker was diagnosed as having lumbar disc degeneration, lumbar disc displacement, failed lumbar back surgery syndrome and chronic pain. Subjective findings (4-16-15, 5-13-15, and 6-11-15) indicated ongoing low back pain with radiation to the left lower extremity. The work status is permanent and stationary. There is no mention of a re-injury to the lower back. Objective findings (4-16-15, 5-13-15, and 6-11-15) revealed lumbar flexion was 35-50 degrees, extension was 5-10 degrees and rotation was 20 degrees bilaterally. As of the PR2 dated 9-10-15, the injured worker reports low back pain that radiates down the left lower extremity. He rates his pain 8 out of 10 with and without medications. Objective findings include "slightly to moderately limited" lumbar range of motion and increased pain with flexion and extension. The treating physician noted that the injured worker has had prior good results with less than 24 total physical therapy visits (date of service not provided). Treatment to date has included a lumbar MRI on 6-9-15 showing an L3-L4 and L4-L5 disc protrusion, Oxycodone, Cyclobenzaprine, Xanax and Soma. The Utilization Review dated 9-18-15, non-certified the request for physical therapy 2x weekly for 4 weeks to the lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 2x wk x 4wks to the lumbar spine: Overturned

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 patient presents with low back pain radiating down the left lower extremity. The request is for PHYSICAL THERAPY 2X WK X 4WKS TO THE LUMBAR SPINE. The request for authorization is dated 09/14/15. MRI of the lumbar spine, 06/09/15, shows annular fissure in posterior aspect of the disc at L3-4; mild hypertrophic changes at facet joint of L4-5 bilaterally; patient is status post partial laminectomy. Patient's diagnoses include lumbar disc degeneration; chronic pain other; lumbar disc displacement; failed back surgery syndrome, lumbar; lumbar post laminectomy syndrome; status post lumbar laminectomy L5-S1; anxiety; depression; iatrogenic opioid dependency; hepatitis C positive. Physical examination of the lumbar spine reveals a well-healed surgical scar. The range of motion of the lumbar spine was slightly to moderately limited. Pain was significantly increased with flexion and extension. Patient's medications include Cyclobenzaprine, Oxycodone, Soma and Xanax. Per progress report dated 09/10/15, the patient is not working. MTUS, Physical Medicine Section, pages 98, 99 states: "Recommended as indicated below. Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." MTUS guidelines pages 98, 99 states that for "Myalgia and myositis, 9-10 visits are recommended over 8 weeks. For Neuralgia, neuritis, and radiculitis, 8-10 visits are recommended." Per progress report dated 09/10/15, treater's reason for the request is "with plan to progress to a home exercise program per therapist's recommendations." The patient continues with low back pain. Given the patient's condition, a short course of physical therapy would appear to be indicated. The patient's physical therapy history is not provided for review to determine previous post-op and any non post-op sessions attended. MTUS allows up to 10 visits of non post-op visits of Physical Therapy. In this case, the request for 8 visits of Physical Therapy appears to be reasonable and within MTUS guidelines for non post-op conditions. Therefore, the request IS medically necessary.