MAXIMUS Federal Services

Case Number:	CM15-0215321		
Date Assigned:	11/05/2015	Date of Injury:	05/16/2013
Decision Date:	12/16/2015	UR Denial Date:	09/28/2015
Priority:	Standard	Application Received:	11/02/2015

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 43 year old male who sustained an industrial injury on 05-16-2013. Medical records indicated the worker was treated for lumbar strain with disc herniation and right lower extremity radicular pain. In the provider notes of 08-24-2015, the worker is seen for ongoing pain in the mid to lower back and left ankle. He rates his pain to be at a 9 without medication. Current medications include Gabapentin, Naproxen, and Norco. An epidural steroid injection was recommended in a pain consultation 04-24-2015. According to the notes "pain management was not changed since then, according to the patient and his pain got worse". The worker presented for re-evaluation for a possible lumbar epidural steroid injection. His diagnoses include Chronic Pain Syndrome, Lumbar-Thoracic Radiculopathy, Lower back pain, Spinal Enthesopathy, Fasciitis, unspecified, and Spinal stenosis- Thoracic . According to provider notes, the worker has failed multiple conservative therapies including physical therapy, nonsteroidal anti-inflammatory drugs, transcutaneous electrical nerve stimulation (TENS) unit, and various medication trials for greater than six months without benefit. The treatment plan is for gabapentin (or Lyrica if Gabapentin not tolerated), naproxen, and Norco and an epidural. Following pain reduction, a trial of physical therapy to continue core muscle strengthening is planned with engagement in formal physical therapy after pain is decreased. Authorization for MRI of the lumbar spine has been requested. Last MRI (10-13-2013) was grossly unremarkable. A request for authorization was submitted for: Physical therapy 2 times a week for 6 weeks to the lumbar spine; Physical therapy 2 times a week for 6 weeks to the thoracic spine; Magnetic resonance imaging (MRI) of the lumbar spine. A utilization review decision on 09-28-2015 non-certified the requests.

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 6 weeks to the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation www.odg-twc.com/preface.htm#physicaltherapyguidelines; ODG, Low Back Chapter.

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

Decision rationale: Time-limited care plan with specific defined goals, assessment of functional benefit with modification of ongoing treatment based upon the patient's progress in meeting those goals and the provider's continued monitoring of successful outcome is stressed by MTUS guidelines. 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. Submitted reports have no acute flare-up or specific physical limitations to support for physical/ occupational therapy. The Chronic Pain Guidelines allow for 9-10 visits of therapy with fading of treatment to an independent self-directed home program. It is unclear how many PT sessions have been completed; however, the submitted reports have not identified clear specific functional improvement in ADLs, functional status, or decrease in medication and medical utilization from the formal physical therapy already rendered to support further treatment for this 2013 injury. There has not been a change in neurological compromise or red-flag findings demonstrated for PT at this time. Submitted reports have also not adequately identified the indication to support for excessive quantity of PT sessions without extenuating circumstances established beyond the guidelines. The physical therapy 2 times a week for 6 weeks to the lumbar spine is not medically necessary and appropriate.

Physical therapy 2 times a week for 6 weeks to the thoracic spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation www.odg-twc.com/preface.htm#physicaltherapyguidelines; ODG, Low Back Chapter.

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

Decision rationale: 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 a week for 6 weeks to the thoracic spine is not medically necessary and appropriate.

Magnetic resonance imaging (MRI) of the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

Decision rationale: Per Treatment Guidelines for the Lower Back Disorders, states criteria for ordering imaging studies include Emergence of a red flag; Physiologic evidence of tissue insult or neurologic dysfunction; Failure to progress in a strengthening program intended to avoid surgery; Clarification of the anatomy prior to an invasive procedure, none identified here. Physiologic evidence may be in the form of definitive neurologic findings on physical examination and electrodiagnostic studies. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist; however, review of submitted medical reports for this chronic 2013 injury have not adequately demonstrated the indication for repeating the MRI of the Lumbar spine when the previous MRI was unremarkable nor document any specific changed clinical findings of neurological deficits, progressive deterioration, or acute red-flag findings to support repeating this imaging study. The patient exhibits continued chronic low back pain with unchanged clinical findings. When the neurologic examination is less clear, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. The Magnetic resonance imaging (MRI) of the lumbar spine is not medically necessary and appropriate.