

Case Number:	CM15-0087918		
Date Assigned:	05/12/2015	Date of Injury:	03/26/2014
Decision Date:	06/11/2015	UR Denial Date:	04/16/2015
Priority:	Standard	Application Received:	05/07/2015

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: 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 female patient who sustained an industrial injury on 06/09/2014. The accident occurred while she was working lifting a wheelchair bound person and experienced acute onset of severe pain about the low back. A recent primary treating office visit dated 03/20/2015 reported the patient with subjective complaint of having constant moderate to severe low back pain rated a 6 out of 10 in intensity. The back pain radiates to the bilateral lower extremity; left side worse and associated with numbness, tingling and burning sensations. She also complains of gastrointestinal and abdominal pain. In addition, she reports symptoms of anxiety, depression, stress, and insomnia. Current prescribed medications include: Ultracet and topical creams. She is attending physical therapy and recently underwent an internal medicine consultation. Objective findings showed the lumbar spine with limited range of motion. Orthopedic testing revealed straight leg raise, Braggard's and Bowstring's all with positive results. Motor strength testing showed weakness of bilateral extensor hallucis longus, gastrocnemius and peroneus longus muscle group. There is sensory deficit noted over the bilateral L5 and S1 dermatomes. Her gait is slow and guarded. She is diagnosed with L4-5 herniated nucleus pulposus with stenosis and ligamentum flavum hypertrophy with left lower extremity radiculitis and radiculopathy. The plan of care noted the patient to continue with physical therapy sessions and prescriptions given for Ultracet and topical cream. The patient underwent lumbar epidural steroid injection, epidurogram, neurogram under fluoroscopy on 10/2/2014.

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 (unspecified): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy, pages 98-99.

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 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 (unspecified) is not medically necessary and appropriate.