

Case Number:	CM14-0134788		
Date Assigned:	08/27/2014	Date of Injury:	07/09/2012
Decision Date:	10/28/2014	UR Denial Date:	08/05/2014
Priority:	Standard	Application Received:	08/21/2014

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. The expert reviewer is Board Certified in Preventative Medicine, has a subspecialty in Occupational Medicine and is licensed to practice in Iowa. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This patient is a 32 year old employee with date of injury of 7/9/2012. Medical records indicate the patient is undergoing treatment for lumbar sprain/strain with radiculopathy. Subjective complaints include lower back pain which is exacerbated by pushing and pulling. His pain is rated as an 8/10. Objective findings include tenderness at the L5-S1 levels, paraspinal muscle and bilateral sacroiliac joints with complains of pain. Braggard's test and straight leg test were positive on the left. Treatment has consisted of PT, chiropractic care and acupuncture. The utilization review determination was rendered on 8/5/2014 recommending non-certification of Physio Therapy 2xwk X6wks Lumbar and Thoracic Spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSIO THERAPY 2XWK X6WKS LUMBAR AND THORACIC SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 65-194, Chronic Pain Treatment Guidelines Physical Therapy, Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Low Back - Lumbar & Thoracic (Acute & Chronic), Physical Therapy, ODG Preface - Physical Therapy

Decision rationale: California MTUS guidelines refer to physical medicine guidelines for physical therapy and recommends as follows: "Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." Additionally, ACOEM guidelines advise against passive modalities by a therapist unless exercises are to be carried out at home by patient. ODG quantifies its recommendations with 10 visits over 8 weeks for lumbar sprains/strains and 9 visits over 8 weeks for unspecified backache/lumbago. Regarding physical therapy, ODG states "Patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy); & (6) When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted." The request is for an additional 12 PT sessions, after six initial visits. The treating physician did not document objective improvement from the previous six PT visits. In addition, there was no documentation of an on going home exercise program or failure of a home exercise program. As such, the request for Physical therapy 3 x week for 4 weeks for the Thoracic Spine is not medically necessary.