

Case Number:	CM14-0170366		
Date Assigned:	10/20/2014	Date of Injury:	04/04/1999
Decision Date:	12/26/2014	UR Denial Date:	09/23/2014
Priority:	Standard	Application Received:	10/15/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in California. 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 is a 36-year old female with a work related injury that occurred April 4, 1999. Treatment history has included medication regime for pain control, physical therapy treatments, lumbar spine fusion surgery, chiropractic therapy and TENS therapy. At the physician's visit dated August 14, 2014, the worker was complaining of lumbar spine pain radiating into the left lower extremity. Pain was described as constant, severe, stabbing, shooting and radiating and exacerbation occurs with all activities. Physical exam was remarkable for mild cervical and thoracic paravertebral tenderness and lumbar pain at the L4-5 and L5-S1 levels. There was also bilateral sacroiliac joint tenderness with referred pain to the gluteals and lower extremity. Lumbar range of motion was reduced 30 percent with pain. The lower extremities had muscle spasms with pain. The worker also complained of shocking pain corresponding to the left L4 and L5 dermatome. Sensation was reduced in the left L4 and L5 dermatome of the lower extremity. Motor strength was 4 on a scale of 5 in the dorsiflexion of the left foot, peripheral pulses were intact and symmetrical bilaterally and gait was abnormal. Diagnoses at this visit were lumbar surgery syndrome, lumbar disc bulges, lumbar radiculitis; neuropathy left L5, sacroiliac joint dysfunction pain and lumbago. Per the authorization dated September 15, 2014, six additional physical therapy visits for the lower back was requested. A progress note dated June 12, 2014 indicates that the patient underwent lumbar spine surgery on March 6, 2014. The treatment plan recommends postoperative physical therapy. A therapy report dated May 22, 2014 indicates that the patient presents for evaluation following lumbar fusion. Numerous therapy reports through August 2014 were included. A progress note dated August 14, 2014 states that "physical therapy has reached a plateau. The utilization review decision dated September 23, 2014 noncertified the six physical therapy visits with the rationale that "the claimant has features of left L4 distribution radiculopathy that needs to be addressed and resolved. Physical therapy in

the presence of ongoing radiculopathy will not succeed since physical therapy does not treat radiculopathy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Six sessions of physical therapy for the lower back: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298, Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 98 of 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Physical Therapy

Decision rationale: Regarding the request for additional physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, there is documentation of completion of prior PT sessions, but there is no documentation of specific objective functional improvement with the previous sessions and remaining deficits that cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised therapy. Furthermore, it is unclear how many therapy sessions the patient has already undergone, making it impossible to determine if the patient has already exceeded the maximum recommended by guidelines for his diagnosis. In light of the above issues, the currently requested additional physical therapy is not medically necessary.