

Case Number:	CM14-0098473		
Date Assigned:	09/16/2014	Date of Injury:	10/08/2007
Decision Date:	10/16/2014	UR Denial Date:	06/18/2014
Priority:	Standard	Application Received:	06/26/2014

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 & Rehabilitation, Pain Medicine: and is licensed to practice in Texas and Oklahoma. 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:

The injured worker is a 60-year-old female who reported a date of injury of 10/08/2007. The mechanism of injury was not indicated. The injured worker had diagnoses of lumbosacral sprain/strain, lumbar disc degeneration, lumbar spondylolisthesis, and lumbar muscle spasm. Prior treatments included massage therapy. The injured worker had an MRI of the lumbar spine on 03/28/2013 with an unofficial report indicating degenerative facet disease and grade 1 anterolisthesis of L3 on L4 and L4-5; an unspecified Electrodiagnostic evaluation on 05/01/2009 with an unofficial report indicating abnormal nerve conduction study findings consistent with S1 radiculitis. Surgeries included epidural steroid injection and a radiofrequency ablation procedure on 08/06/2013. The injured worker had complaints of persistent back pain. The clinical note dated 08/01/2014 noted the injured worker had normal muscle tone of all extremities without atrophy. The injured worker had 5/5 Muscle strength of the lower extremities bilaterally, intact sensation to light touch and pinprick of the lower extremities bilaterally, and a negative straight leg raise with spasm and guarding noted of the lumbar spine. Medications included hydrocodone, atenolol, and hydrochlorothiazide. The treatment plan included the physician's recommendation for the injured worker to complete massage therapy and to follow up in 4 weeks. The rationale and Request for Authorization form were not provided within the medical records received.

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional PT x 6, lower back: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines; Physical Medicine Guide. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) : Lumbar Chapter; Physical /Occupational Therapy: ODG Physical Therapy Guidelines ; Lumbar sprains and strains

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: The injured worker had complaints of persistent back pain. The California MTUS Guidelines recommend active therapy based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires and internal effort by the individual to complete a specific exercise or task. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. The guidelines recommend 9 visits over 8 weeks, allowing for fading of treatment frequency from up to 3 or more visits to 1 or less, plus active self-directed home physical therapy. There is a lack of documentation the injured worker had beneficial functional gains with prior physical therapy to warrant additional physical therapy. Furthermore, there is a lack of the sessions of physical therapy the injured worker completed to justify the necessity, as the guidelines indicate 9 sessions over 8 weeks. There is a lack of documentation the injured worker has significant functional deficits to warrant physical therapy. As such, the request is not medically necessary.