

Case Number:	CM13-0064317		
Date Assigned:	01/03/2014	Date of Injury:	06/08/2009
Decision Date:	10/13/2015	UR Denial Date:	11/13/2013
Priority:	Standard	Application Received:	12/11/2013

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: Emergency Medicine

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 50 year old female, who sustained an industrial injury on June 8, 2009. The initial symptoms reported by the injured worker are unknown. The injured worker was currently diagnosed as having left sacroiliac joint dysfunction, L5-S1 degenerative disc disease and annular tear, left leg radiculopathy, chronic intractable pain and status post L5-S1 anterior and posterior fusion with cage and instrumentation with left L5-S1 laminotomy. Treatment to date has included medication, diagnostic studies, surgery and injection. A right-sided L5-S1 transforaminal epidural injection provided 50% relief of her symptoms. On July 27, 2015, the injured worker complained of pain over the left sacroiliac joint rated as a 10 on a 1-10 pain scale without medications and as an 8 on the pain scale with medications. She reported lower back pain and numbness down the right lower extremity. Physical examination revealed tenderness to palpation over the lumbosacral junction and over the left sacroiliac joint. Straight leg raise test was positive on the right lower extremity. She also had positive Fortin's on the left, positive pelvic compression and distraction on the left and positive thigh thrust on the left. Treatment recommendations included ongoing pain management care for medication management, Norco, Medrol Dose pack and a follow-up visit. A request was made for physiotherapy two times a week for three weeks for the low back.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSIOTHERAPY 2X A WEEK FOR 3 WEEKS FOR THE LOW BACK: Upheld

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment 2009, Section(s): Low Back.

Decision rationale: The requested PHYSIOTHERAPY 2X A WEEK FOR 3 WEEKS FOR THE LOW BACK, is not medically necessary. CA MTUS Post-Surgical Treatment Guidelines, Low Back, Intervertebral disc disorders without myelopathy, Post-surgical treatment(fusion), Page 26, recommend up to 34 post-op physical therapy sessions for this condition, and the initial course of therapy means one half of the number of visits specified in the general course of therapy for the specific surgery in the post surgical physical medicine treatment recommendations set forth in subdivision (d) (1) of this section. The injured worker has pain over the left sacroiliac joint rated as a 10 on a 1-10 pain scale without medications and as an 8 on the pain scale with medications. She reported lower back pain and numbness down the right lower extremity. Physical examination revealed tenderness to palpation over the lumbosacral junction and over the left sacroiliac joint. Straight leg raise test was positive on the right lower extremity. She also had positive Fortin's on the left, positive pelvic compression and distraction on the left and positive thigh thrust on the left. The treating physician has not documented the medical necessity for additional physical therapy beyond referenced guideline recommendations to accomplish a transition to an independent dynamic home exercise program. The criteria noted above not having been met, PHYSIOTHERAPY 2X A WEEK FOR 3 WEEKS FOR THE LOW BACK is not medically necessary.