

Case Number:	CM14-0213053		
Date Assigned:	12/30/2014	Date of Injury:	02/23/2014
Decision Date:	02/27/2015	UR Denial Date:	11/21/2014
Priority:	Standard	Application Received:	12/19/2014

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. 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 & Rehabn

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 patient is a 61 year old male with an injury date on 2/23/14. The patient complains of continuing back pain that limits his activities of daily living, especially severe upon awakening in the morning per 11/14/14 report. The patient also has severe retro-orbital pain on the right, occasionally associated with vertigo/nausea per 11/14/14 report. The patient's radicular pain (unspecified) is resolved per 10/13/14 report. Based on the 11/14/14 progress report provided by the treating physician, the diagnoses are: 1. s/p left L4-5 microdecompression and discectomy on 7/22/14. 2. Continued back pain with disc degeneration. 3. Right retro-orbital pain with vertigo. A physical exam on 11/14/14 showed "Normal sensory exam. Normal reflexes. Full motor strength in all groups." No range of motion testing of the lumbar spine post 7/22/14 report was found in provided documentation. The patient's treatment history includes medications, MRI L-spine, X-ray L-spine. The treating physician is requesting physical therapy 2-3 times per week for 8 to 12 weeks. The utilization review determination being challenged is dated 11/21/14 and modifies request to 6 physical therapy sessions. The requesting physician provided treatment reports from 3/28/14 to 12/8/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy 2-3 times per week for 8 to 12 weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Post-surgical guidelines, Low Back Page(s): 25-26.

Decision rationale: This patient presents with back pain, retro-orbital pain on the right and is s/p left L4-5 micro decompression and discectomy on 7/22/14. The treater has asked for PHYSICAL THERAPY 2-3 TIMES PER WEEK FOR 8 TO 12 WEEKS on 11/14/14. Review of the reports do not show any evidence of recent physical therapy being done. For discectomy, MTUS post-surgical guidelines for the low back recommend 16 visits over 8 weeks within postsurgical physical medicine treatment period of 6 months. In this case, the patient has chronic back pain. The treater has requested physical therapy 2-3 times a week for 8 to 12 weeks. While a course of 16 postsurgical physical therapy would be reasonable, the requested 36 physical therapy sessions exceed MTUS postsurgical guidelines for the patient's condition. The request IS NOT medically necessary.