

Case Number:	CM14-0213303		
Date Assigned:	12/30/2014	Date of Injury:	04/06/2007
Decision Date:	02/24/2015	UR Denial Date:	12/03/2014
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: Family Practice

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 61-year-old flight attendant reported injuries as a result of being struck by an aircraft door handle on 4/6/07. Treatment has included an L2-S1 fusion performed 1/8/14 and a fusion/decompression for the left lower extremity performed 1/16/14. Non-surgical treatment has included nerve stimulation physical therapy, ice treatment, heat treatment, facet joint injections, epidural steroid injections, chiropractic manipulation, acupuncture, traction, aquatic therapy, and trigger point injections. There are multiple notes in the available record from the patient's current primary treater, a physiatrist, and from the treating surgeon. None of the notes document the patient's functional status beyond her continued problems with walking. She was not working for the entire period for which there are available notes: 6/12/14 through 12/29/14. The 11/24/14 notes from the primary provider states that the patient's low back and left leg pain has increased, and her right leg pain is unchanged. A visit with the surgeon had a resulted in a decision to hold off on further PT until more healing of her back surgery has occurred. The patient states that she exercises daily, including walking and water aerobics. She is using a Butrans patch and taking Norco10 every 4-6 hours as needed. Notable exam findings include decreased sensation in a left L5 distribution, and decreased strength of the left lower extremity, most severe with hip flexion (3/5). Left ankle dorsiflexion is noted to be 4-/5, which the provider states is improved. Diagnoses include difficulty walking due to left foot drop, post laminectomy with myelopathy, post laminectomy syndrome, lumbar disc displacement L4-5, myospasm, and cervical dystonia. Discussion includes a statement that the fusion is not taking at L2, and that the patient should wear a lumbar spine brace in public and for physical therapy. A

decompression and re-fusion is planned, apparently in 1/15. The provider's current plan includes starting physical therapy for the leg only, continuing current medications, and considering an epidural steroid injection. Somewhat inexplicably, the records contain many of the notes from 37 visits of physical therapy that occurred from 5/29/14 to 12/29/14, including at least twice monthly visits from 10/14-12/14. Virtually every note documents that the patient is not doing home exercises consistently, and that she has decreased core and abdominal strength as well as decreased left lower extremity strength. Virtually all notes also state that the patient's left leg still can drag while walking, and that she continues to wear a brace. The PT notes do not contain sufficient objective measurements of strength to determine if there has been any progress, but it appears likely that there has not. Extensor hallucis longus testing is reported as "fair" initially, and ankle dorsiflexion is reported as 4-/5 on both 9/4/14 and 12/9/14. A request for 8 physical therapy sessions was modified in UR on 12/3/14, and 6 of the 8 sessions were certified. It appears likely that the reviewer did not have access to PT records and was unaware that the patient had been participating in ongoing PT for months. MTUS Chronic Pain, Physical Medicine was cited as the basis for the decision.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy x 8 sessions for the left leg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Introduction; Physical Medicine Page(s): 9; 98-99.

Decision rationale: According to the first citation above, all therapies are focused on the goal of functional restoration rather than merely the elimination of pain, and assessment of treatment efficacy is accomplished by reporting functional improvement. The second citation states that passive therapy is for early phase of treatment. Active therapy recommended over passive care, with transition to home therapy. The clinical documentation in this case does not support the provision of additional physical therapy to this patient. There is clear documentation that she has already had 31 PT sessions, and should have made a transition to home therapy. These sessions did not result in any functional recovery. She has not returned to work in any capacity. The provider has not documented any goals that could not be accomplished with home therapy and would require additional formal physical therapy. In fact, the provider seems to be totally unaware that the patient has already had 31 PT sessions, and has not addressed the reasons for her lack of response to it. Based on the MTUS citations above and on the clinical documentation provided for my review, 8 sessions of physical therapy for the left leg are not medically necessary because the patient demonstrated no functional recovery with extensive previous therapy, and because her provider has not outlined any goals that could not be accomplished by home exercise therapy. Therefore this request is not medically necessary.