

Case Number:	CM15-0112789		
Date Assigned:	06/19/2015	Date of Injury:	02/14/2014
Decision Date:	07/20/2015	UR Denial Date:	05/28/2015
Priority:	Standard	Application Received:	06/11/2015

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: New Jersey, Alabama, California
 Certification(s)/Specialty: Neurology, Neuromuscular 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 53 year old female with an industrial injury dated 02/14/2014. Her diagnoses included lumbago - pain lumbar spine, lumbar/lumbosacral disc degeneration and left radiculitis. Prior treatment included epidural steroid injection with minimal relief, medial branch block of lumbar 3-5 with 100% relief, MBRF lumbar 3- sacral 1 with 30% relief except over the sacroiliac joint and left sacroiliac joint intra articular injection, some relief. She presents on 05/08/2015 stating she is able to sleep on her left side with "a lot of burning pain." Previously 90% of pain was located in right lower back and down the legs. She stated the sacroiliac joint injection did improve the pain somewhat in the back and now she is able to lie down on the left side. She complains of burning pain that radiates down to the legs, occurring more frequently to the point that she has to use a cane to walk. She also notes the sensation radiates across her back. Her average pain is 6 out of 10. Pain level without pain medication is 7-8 out of 10 and pain level with pain medication is 6-7 out of 10. Documentation states "without pain medication the patient would be unable to walk, stand, sit and sleep." Tylenol # 3 improves pain 30% but causes dry mouth. Physical exam revealed the injured worker to be well nourished and in mild distress using a cane to walk. Lumbar examination showed passive range of motion to be restricted due to pain. Sensation was intact except left lateral thigh. Treatment plan included lumbar spine MRI, Neurontin, continue physical therapy and home exercise program. Other treatment plan included Tylenol # 3, continue Elavil for insomnia, use cane until MRI done and to return in one week. The request is for physical therapy for the low back 2 times weekly for 4 weeks, quantity: 8 sessions.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy for the low back 2 times weekly for 4 weeks, quantity: 8 sessions: Upheld

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

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

Decision rationale: According to MTUS guidelines, Physical Medicine is "Recommended as indicated below. Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. Active therapy is 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 an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. (Colorado, 2002) (Airaksinen, 2006) Patient-specific hand therapy is very important in reducing swelling, decreasing pain, and improving range of motion in CRPS. (Li, 2005) The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of patients with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment." (Fritz, 2007) In this case, the frequency of the treatment should be reduced from 8 to 3 or less sessions. More sessions will be considered when functional and objective improvement are documented. In addition, there is no documentation that the patient cannot perform home exercise. Therefore, the request for 8 sessions of physical therapy for the low back is not medically necessary.