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| Case Number: | CM15-0117360 | | |
| Date Assigned: | 06/25/2015 | Date of Injury: | 03/03/2006 |
| Decision Date: | 07/24/2015 | UR Denial Date: | 05/22/2015 |
| Priority: | Standard | Application Received: | 06/17/2015 |

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: California, Indiana, New York
Certification(s)/Specialty: Internal 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 35-year-old male who sustained an industrial injury on 3/3/2006 resulting in upper and lower back pain. The injured worker was diagnosed with lumbosacral spondylosis and thoracic/lumbosacral neuritis. Documented treatment includes medication, facet joint block and SI injection, and lumbar total disc replacement of L5-S1. The injured worker has reported minimal improvement in pain levels and presently complains of pain and numbness bilaterally to lower extremities. The treating physician's plan of care includes 12 sessions of physical therapy. He is presently not working.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 2 times a week for 6 weeks for the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78-92, 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back section, Physical therapy.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, physical therapy two times per week times six weeks to the lumbar spine is not medically necessary. Patients should be formally assessed after a six visit clinical trial to see if the patient is moving in a positive direction, no direction or negative direction (prior to continuing with physical therapy). When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted. In this case, the injured worker's working diagnoses are lumbosacral spondylosis; and thoracic/lumbosacral neuritis unspecified; status post discectomy at L5- S1 and placement interbody implant L5-S1. The documentation does not provide prior physical therapy sessions to date. The injured worker received postoperative physical therapy; however, there is no physical therapy progress notes documented medical record. There is no documentation demonstrating objective functional improvement from prior physical therapy. Consequently, absent clinical documentation demonstrating objective functional improvement from prior physical therapy, total number of physical therapy sessions to date, and unremarkable physical examination of the lumbar spine and compelling clinical facts indicating additional physical therapy is warranted, physical therapy two times per week times six weeks to the lumbar spine is not medically necessary.