

Case Number:	CM15-0164457		
Date Assigned:	09/01/2015	Date of Injury:	01/25/2010
Decision Date:	12/09/2015	UR Denial Date:	07/23/2015
Priority:	Standard	Application Received:	08/21/2015

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: Texas, Florida, California

Certification(s)/Specialty: Preventive Medicine, Occupational 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 51-year-old female who sustained an industrial injury on 1-25-2010 and has been treated for cervical disc disease, bilateral De Quervain's tenosynovitis and epicondylitis, and lumbar disc disease with radiculopathy. MRI dated 3-13-2015 showed lumbar degenerative disc disease with disc herniation L5-S1 with stenosis. On 7-10-2015 the injured worker reported pain rated at 9 out of 10 on a VAS scale. The low back pain had subsided after a lumbar epidural injection 6-13-2015 for five days with 50 percent relief but has returned. Objective lumbar examination revealed "limited" range of motion, tightness and tenderness over the lumbar paravertebral muscles, positive left-sided straight leg raises both seated and lying; and decreased sensation in the L5 and S1 dermatomes on the left. Documented treatment includes lumbar steroid epidural injection, Tylenol No. 3, Motrin, and Gabapentin. There is no documentation indicating previous physical therapy. The treating physician's plan of care includes 12 sessions of physical therapy for the low back, which was non-certified on 7-23-2015. She is presently not working.

IMR ISSUES, DECISIONS AND RATIONALES

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

12 Physical Therapy for the Lower Back, 2 times a week for 6 weeks, as an outpatient:

Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines.

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

Decision rationale: Chronic Pain Medical Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009), page 98 of 127. This claimant was injured 5 years ago, with cervical disc disease, bilateral De Quervain's, epicondylitis and lumbar disc disease with radiculopathy. Though the injury was 5 years ago, there oddly is no mention at all of any physical therapy in those 5 years, which is not clinically credible. The MTUS does permit physical therapy in chronic situations, noting that one should allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. The conditions mentioned are Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks; Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2) 8-10 visits over 4 weeks; and Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks. This claimant does not have these conditions. And, after several documented sessions of therapy, it is not clear why the patient would not be independent with self-care at this point. Also, there are especially strong caveats in the MTUS/ACOEM guidelines against over treatment in the chronic situation supporting the clinical notion that the move to independence and an active, independent home program is clinically in the best interest of the patient. They cite: Although mistreating or under treating pain is of concern, an even greater risk for the physician is over treating the chronic pain patient. Over treatment often results in irreparable harm to the patient's socioeconomic status, home life, personal relationships, and quality of life in general. A patient's complaints of pain should be acknowledged. Patient and clinician should remain focused on the ultimate goal of rehabilitation leading to optimal functional recovery, decreased healthcare utilization, and maximal self-actualization. This request is not medically necessary.