

Case Number:	CM15-0179531		
Date Assigned:	09/21/2015	Date of Injury:	01/17/2005
Decision Date:	10/23/2015	UR Denial Date:	08/11/2015
Priority:	Standard	Application Received:	09/11/2015

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: 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 48 year old male, who sustained an industrial injury on 1-17-2005. The injured worker was diagnosed as having lumbago. Treatment to date has included diagnostics, medications, and unspecified physical therapy. A progress report (11-25-2014) noted worsening pain since the last week after having unspecified physical therapy. On 4-03-2015, the injured worker complains of pain, stiffness, and decreased range of motion of the low back. Physical exam of the lumbar spine noted tenderness, effusion, and positive straight leg raising. Range of motion showed full forward flexion, 10 degrees extension, 15 degrees lateral bending, and 10 degrees axial rotation. Lower extremity motor strength was noted 4 of 5. X-rays of the coccyx (1-23-2015 and 4-03-2015) showed slight anterior angulation of the distal segment of the coccyx, otherwise normal. X-rays of the lumbar spine (1-23-2015 and 4-03-2015) showed spondylitis changes of the L4-L5 and S1 vertebra. X-ray of the sacrum (1-23-2015) showed L5-S1 spondylolisthesis changes and L5-S1 spondylitic changes with bilateral sacroiliitis (4-03-2015), without fracture or dislocation. X-ray of the lumbar spine (7-06-2015) showed 3 degree dextroscoliosis and degenerative changes at L1-2 and L3-4 through L5-S1. Physical therapy was recommended to increase strength, range of motion, and flexibility. Current medication regimen was not noted, noting request for Motrin and Tramadol. His work status was noted as "should be on light duty" and "avoid bending, climbing and twisting activities". The treatment plan included lumbar physical therapy, 3x4, non-certified by Utilization Review on 8-11-2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar Physical Therapy Three (3) Times a Week for Four (4) Weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004, and Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back - Lumbar & Thoracic (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back section, Physical therapy.

Decision rationale: Pursuant and to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, lumbar physical therapy three times per week times four weeks 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 exceed the guideline, exceptional factors should be noted. In this case, the injured worker's working diagnoses are low back pain; lumbar sprain strain; and disc disorder lumbar region. Date of injury is January 17, 2005. Request for authorization is August 4, 2015. According to an April 17, 2015 progress note, subjective complaints include low back pain that radiates to the left thigh. The treating provider is requesting additional physical therapy. The total number of physical therapy sessions to date is not documented. There is no documentation demonstrating objective functional improvement. There are no compelling clinical facts indicating additional physical therapy as clinically indicated. Based on the clinical information and medical records, peer-reviewed evidence-based guidelines, no documentation demonstrating objective functional improvement and no compelling clinical facts indicating additional physical therapy is warranted, lumbar physical therapy three times per week times four weeks is not medically necessary.