

Case Number:	CM15-0090752		
Date Assigned:	05/15/2015	Date of Injury:	08/03/2012
Decision Date:	06/16/2015	UR Denial Date:	04/13/2015
Priority:	Standard	Application Received:	05/11/2015

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 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 39 year old female, who sustained an industrial injury on 8/3/12. The injured worker was diagnosed as having low back pain, large extruded disc L5-S1, disc protrusion L4-5, spinal stenosis of lumbar spine, radiculopathy of bilateral lower extremities and neuropathic pain. Treatment to date has included cervical discectomy, physical therapy, oral medications and home exercise program. (MRI) magnetic resonance imaging performed on 1/6/15 revealed L5-S1 right paracentral far lateral disc herniation and right facet hypertrophy causing right greater than left neuroforaminal narrowing. Currently, the injured worker complains of lumbar pain rated 6-7/10 with intermittent radicular pain to both legs associated with numbness and tingling. She notes improvement with cognitive therapy and oral medications. Physical exam noted decreased range of motion of lumbar spine. The treatment plan included physical therapy and refilling of Tizanidine and Gabapentin.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy for the lumbar spine, three times a week for six weeks: Upheld

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

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

Decision rationale: According to the California MTUS Treatment guidelines, physical therapy (PT) is indicated for the treatment of musculoskeletal pain. Recommendations state that for most patients with more severe and sub-acute low back pain conditions, 8 to 12 visits over a period of 6 to 8 weeks is indicated as long as functional improvement and program progression are documented. 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. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. In this case, the patient completed 12 post-operative physical therapy sessions. There is no documentation indicating that she had a defined functional improvement in her condition. There is no specific indication for the requested additional PT sessions (3 x week for 6 weeks). Medical necessity for the requested service has not been established. The requested service is not medically necessary.