

Case Number:	CM15-0092355		
Date Assigned:	05/18/2015	Date of Injury:	06/12/2013
Decision Date:	06/24/2015	UR Denial Date:	04/13/2015
Priority:	Standard	Application Received:	05/13/2015

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 33 year old male, who sustained an industrial injury on 6/12/13. He reported pain in his left shoulder and low back. Diagnoses have included bilateral spondylosis with spondylolisthesis at L5-S1. Treatment to date has included chiropractic treatment, acupuncture, massage, transcutaneous electrical nerve stimulation (TENS) unit and medication. According to the progress report dated 2/19/2015, the injured worker complained of ongoing low back pain and radicular right leg pain averaging 7/10. Current medications included Tramadol, Omeprazole, Gabapentin and a sleeping pill. Exam of the lumbar spine revealed tenderness to palpation over the right lower lumbar spine and over the sciatic notch. Straight leg raise test was positive on the right. Lumbar range of motion was diminished. The injured worker had an altered gait with a limp on the right leg. The treatment plan was for the injured worker to undergo anterior lumbar interbody fusion at L5-S1 with pedicle screw instrumentation and posterolateral fusion with bilateral facetectomy at L5-S1 for nerve root decompression and stabilization of the spine. Authorization was requested for post-op physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post-Operative Physical therapy 3 x 6 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

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, postoperative physical therapy three times per week times six 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 exceeds the guideline, exceptional factors should be noted. In this case, the injured worker's working diagnoses are lumbar spine disc recent exacerbation. The injured worker was under the care of a neurosurgeon (February 19, 2015 progress note) who submitted a request for an L5 - S1 posterior spinal fusion with interbody cage implantation and pedicle screw instrumentation and lumbar spine exacerbations. There is no documentation of recent physical therapy in the medical record. The utilization review indicates the L5 - S1 posterior spinal fusion with interbody cage implantation and pedicle screw instrumentation was not authorized. If the surgery is not authorized, postoperative physical therapy is not authorized. In the alternative, the guidelines allowed a six visit clinical trial. The treating provider requested physical therapy three times per week times six weeks. This request is in excess of the recommended guidelines (if the surgery were authorized). This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur. Based on the clinical information in the medical record and the peer-reviewed evidence-based guidelines, postoperative physical therapy three times per week times six weeks is not medically necessary.