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| Case Number: | CM14-0214459 | | |
| Date Assigned: | 01/14/2015 | Date of Injury: | 02/27/2012 |
| Decision Date: | 10/13/2015 | UR Denial Date: | 11/20/2014 |
| Priority: | Standard | Application Received: | 12/22/2014 |

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 (IW) is a 43 year old female who sustained an industrial injury on 02-27-2012. The injured worker was diagnosed as having Degenerative Disc Disease; Lumbar status post left L5-S1 microdiscectomy, Lumbosacral radiculopathy, Lumbar disc herniation with radiculopathy, and chronic low back pain. Treatment to date has included an implanted spinal cord stimulator (SCS) and medications. On 05-14-2014 (the day of the spinal cord stimulator implantation trial,) her pain was reported as 7 on a scale of 10 on without the SCS and 3 on a scale of 10 (60% overall pain reduction) with the SCS. Medications as of 08-26-2014 the worker was on Percocet, cyclobenzaprine, and Neurontin. As of 09-17-2014, the worker was noted to be still getting bad sciatic pain and bad flare-ups and was taking medication as before. Her symptoms are described as stable and persistent. In the exam notes of 11-10-2014, the injured worker complains of persistent severe left leg spasms and pain during the prior week. She had a permanent spinal cord stimulator placed which was re-programmed 11-06-2014 in response to the increased pain. Her pain at the 11-10-2014 visit is rated a 5-6 on a scale of 0-10, and her spasms and pain has increased. On exam, she has an antalgic gait with a decreased stance phase on the left, tenderness and spasm of lumbar paraspinals bilateral. Her range of motion exam was not attempted. She has a positive seated leg raise on the left. The worker is in a medical retirement. The plan was for continued care per the pain management specialist, and physical therapy. There is no documentation of prior physical therapy in the medical records reviewed. A request for authorization was submitted 11/18/2014 for Physical Therapy 2 Times a Week for 12 Weeks (24 sessions total) to The Cervical and Lumbar Spine, and Back to Work Program with Work Hardening Modalities of Heat Cold and Ultrasound (unspecified sessions). A utilization

review decision (11-20-2014) modified the request for Physical Therapy 2 Times A Week for 12 Weeks (24 sessions total) to The Cervical and Lumbar Spine to approve six visits (2 Times A Week for 3 Weeks).

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 12 Weeks (24 sessions total) to The Cervical and Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004, and Postsurgical Treatment 2009. Decision based on Non-MTUS Citation ODG Physical Therapy Guidelines (Lumbar).

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 Neck 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 12 weeks (24 sessions) to the cervical and 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 committee 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 radiculopathy; lumbar disc herniation with radiculopathy; and chronic low back pain. The injured worker is status post left L5 - S1 microdiscectomy and status post left L5 - S1 re-exploration/discectomy for left S1 radiculopathy. Date of injury is February 27, 2012. Request for authorization is November 13, 2014. According to a November 10, 2014 progress note, the injured workers primary complaint is left leg spasm. The worker is status post spinal cord stimulator placement May 7, 2014. Objectively, there is limited range of motion of the lumbar spine and range of motion was not attempted. There is no cervical spine physical examination. There is no clinical discussion, indication or rationale for a work hardening program. There is no return to work plan in the medical record. There are no physical therapy progress notes in the medical record. There is no documentation of prior physical therapy and associated objective functional improvement. The total number of physical therapy sessions to date is not specified. Based on the clinical information in the medical record, peer-reviewed evidence-based guidelines, no documentation reflecting the total number of physical therapy sessions to date, no documentation demonstrating objective functional improvement with prior physical therapy, no compelling clinical facts indicating additional physical therapy is clinically warranted (over the recommended guidelines) and no physical examination of the cervical spine, physical therapy two times per week times 12 weeks (24 sessions) to the cervical and lumbar spine is not medically necessary.

Back to Work Program with Work Hardening Modalities of Heat Cold and Ultrasound (unspecified sessions): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Work conditioning, work hardening. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Work conditioning, work hardening.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, back to work program with work hardening modalities of heat, cold, ultrasound (unspecified number of sessions) is not medically necessary. Work hardening/conditioning is recommended as an option for treatment of chronic pain syndromes depending upon availability of quality programs. The criteria for admission to a work hardening program include, but are not limited to, screening documentation; diagnostic interview with a mental health provider; job demands; functional capacity evaluations; previous physical therapy; rule out surgery; other contraindications; a return to work plan; drug problems; program documentation; supervision; a trial (of no longer than 1 to 2 weeks without evidence of patient compliance and demonstrated significant gains; concurrently working; etc. "There is no high-grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities such as traction, heat/cold applications, massage, diathermy, cutaneous laser treatment, ultrasound, transcutaneous electrical neurostimulation (TENS) units, and biofeedback. These palliative tools may be used on a trial basis but should be monitored closely. Emphasis should focus on functional restoration and return of patients to activities of normal daily living". In this case, the injured worker's working diagnoses are lumbosacral radiculopathy; lumbar disc herniation with radiculopathy; and chronic low back pain. The injured worker is status post left L5 - S1 microdiscectomy and status post left L5 - S1 re-exploration/discectomy for left S1 radiculopathy. Date of injury is February 27, 2012. Request for authorization is November 13, 2014. According to a November 10, 2014 progress note, the injured workers primary complaint is left leg spasm. The worker is status post spinal cord stimulator placement May 7, 2014. Objectively, there is limited range of motion of the lumbar spine and range of motion was not attempted. There is no cervical spine physical examination. There is no clinical discussion, indication or rationale for a work hardening program. There is no return to work plan in the medical record. There are no physical therapy progress notes in the medical record. There is no documentation of prior physical therapy and associated objective functional improvement. The total number of physical therapy sessions to date is not specified. The guidelines do not support heat/ cold applications or ultrasound. Additionally, the request does not indicate the specific number of sessions. Based on clinical information in the medical record, peer-reviewed evidence-based guidelines, guideline non-recommendations for heat/cold applications and ultrasound based on no high-grade scientific evidence to support the effectiveness or ineffectiveness, no discussion, and no indication or clinical rationale for a work hardening program. Back to work program with work hardening modalities of heat, cold, ultrasound (unspecified number of sessions) is not medically necessary.