

<b>Case Number:</b>	CM13-0007387		
<b>Date Assigned:</b>	09/13/2013	<b>Date of Injury:</b>	01/17/2011
<b>Decision Date:</b>	02/18/2014	<b>UR Denial Date:</b>	07/26/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/02/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Family Practice, and is licensed to practice in Texas. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 32-year-old female who sustained a work-related injury on 01/17/2011. The clinical information indicates the patient has undergone an unknown number of physical therapy sessions. Subjectively, the patient reported low back and joint pain which she rated 8/10. Objective findings revealed tenderness and tightness to palpation, muscle spasms, pain with range of motion of the lumbar spine, and full range of motion of the cervical spine. Neurologically, the patient had altered sensation to the left lower extremity great toe, as well as the thumb, index, and 2nd fingers of the left hand. Request for authorization was made for a lumbar bilateral facet joint injection.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy 3xWk x 8wks of left neck:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Section Physical Medicine guidelines Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck, Upper Back and Low back

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Section Physical Medicine Page(s): 98-99.

**Decision rationale:** The CA MTUS Guidelines for physical medicine state that "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, and that patients are instructed in and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels". The clinical provided indicated that the patient had undergone an unknown number of physical therapy sessions in the past. However, there was lack of documentation submitted for review to determine the patient's progress or compliance with physical therapy or with a home exercise program. Furthermore, there is no rationale as to why the patient is cannot transition to an independent home exercise program for continued functional benefit and pain reduction. As such, the request for physical therapy 3 times a week x 8 weeks of the left neck is non-certified.

**Physical therapy 3xWk x 8wks of left back:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Section Physical Medicine guidelines Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck, Upper Back and Low back

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Section Physical Medicine Page(s): 98-99.

**Decision rationale:** The CA MTUS Guidelines for physical medicine state that "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, and that patients are instructed in and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels." The clinical provided indicated the patient had undergone an unknown number of physical therapy sessions in the past. However, there was lack of documentation submitted for review to determine the patient's progress or compliance with physical therapy or with a home exercise program. Furthermore, there is no rationale as to why the patient is unable to transition to an independent home exercise program for continued functional benefit and pain reduction. As such, the request for physical therapy 3 times a week x 8 weeks of the left back is non-certified.