

<b>Case Number:</b>	CM13-0023012		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	05/17/2001
<b>Decision Date:</b>	03/24/2014	<b>UR Denial Date:</b>	09/05/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/11/2013

### 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 Physical Medicine and Rehabilitation, 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 59-year-old male who reported an injury on 5/17/01 after a motor vehicle accident. The patient sustained injury to the low back that ultimately resulted in multiple surgical interventions. The patient's postsurgical chronic pain was managed with multiple medications, and a spinal cord stimulator trial was recommended. The patient's most recent clinical examination findings included persistent pain complaints of the low back radiating into the bilateral lower extremities. Physical findings included decreased muscle strength rated at a 4/5 with a decreased patellofemoral reflex on the right side and a positive bilateral facet loading test with paraspinal musculature tenderness to palpation along the right side. The patient's diagnoses included displacement of thoracic or lumbar intervertebral disc without myelopathy, thoracic or lumbosacral neuritis or radiculitis, spasm of muscles, and lateral epicondylitis. The patient's treatment plan included continuation of medications and participation in a home exercise program.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**physical therapy for the right elbow:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

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

**Decision rationale:** The California MTUS recommends physical therapy for patients who have pain complaints, weakness, and range of motion deficits. The clinical documentation submitted for review does not provide an adequate assessment of the patient's right elbow to support the need for physical therapy. Additionally, the request as it is written does not specifically identify a duration and frequency of treatment. Therefore, medical necessity cannot be determined. As such, the requested physical therapy is not medically necessary or appropriate.