

<b>Case Number:</b>	CM13-0051914		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	08/20/1999
<b>Decision Date:</b>	11/03/2014	<b>UR Denial Date:</b>	10/14/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/29/2013

### 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. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. 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/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:

There were 14 pages provided for this review. The application for independent medical review was signed on October 23, 2013. The date of injury was August 20, 1999 and the date of the utilization review in question was October 4, 2013. Per the records provided, the patient was described as a 71-year-old man. The mechanism of injury and the involved body parts were not stated in the documentation. The current diagnoses however were lumbar stenosis and radiculopathy. The request was made for four therapy visits for the lumbar spine. As of September 24, 2013 he had low back pain radiating to the right leg and foot. There was painful range of motion, spasm, atrophy and weakness of the right L5-S1 dermatome and a positive straight leg raise on the right. The medicines were Celebrex, baclofen, and hydrocodone. There was a lumbar MRI. There was a therapy request but only with passive modalities and they discussed possible lumbar epidural steroid injections and surgery. The functional response to the unspecified number of prior therapy visits since 1999, if any, was not documented to justify four more sessions. Also, it is noted the care is passive in nature, which, although it provides comfort, does not add to active rehabilitation and is not recommended.

### 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 2 WEEKS FOR LUMBAR:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 9792.26 MTUS (Effective July 18, 2009) Page(s): 98 of 127.

**Decision rationale:** The MTUS does permit physical therapy in chronic situations, noting that one should allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. The conditions mentioned are myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks; neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2) 8-10 visits over 4 weeks; and reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks. This claimant does not have these conditions. And, after several documented sessions of therapy, it is not clear why the patient would not be independent with self-care at this point. Also, there are especially strong caveats in the MTUS guidelines against over treatment in the chronic situation supporting the clinical notion that the move to independence and an active, independent home program is clinically in the best interest of the patient. They cite: 1. Although mistreating or under treating pain is of concern, an even greater risk for the physician is over treating the chronic pain patient...Over treatment often results in irreparable harm to the patient's socioeconomic status, home life, personal relationships, and quality of life in general. 2. A patient's complaints of pain should be acknowledged. Patient and clinician should remain focused on the ultimate goal of rehabilitation leading to optimal functional recovery, decreased healthcare utilization, and maximal self actualization. The functional response to the unspecified number of prior therapy visits since 1999, if any, was not documented to justify four more sessions. Also, it is noted the care is passive in nature, which, although it provides comfort, does not add to active rehabilitation and is not recommended. The request is not medically necessary.