

<b>Case Number:</b>	CM13-0052958		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	01/17/2010
<b>Decision Date:</b>	03/10/2014	<b>UR Denial Date:</b>	10/22/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/18/2013

### 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 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 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 47-year-old male who sustained an injury on January 17, 2010 while employed by the [REDACTED]. The request under consideration includes physical therapy for the lumbar, two (2) times a week for six (6) weeks. Diagnoses include L5-S1 fusion on February 4, 2013, spinal cord stimulator placement in 2012; and (non-industrial AVN) right total hip arthroplasty (THA) in May 2010. The report on September 25, 2013 noted exam findings of 5/5 motor strength without specified range of motion documented. The request for additional physical therapy was non-certified on October 22, 2013 citing guidelines criteria and lack of medical necessity. The report of November 16, 2013 from [REDACTED], orthopedic panel qualified medical evaluation (QME) noted the patient with low back pain radiating down the right lower extremity with muscle spasm; right hip discomfort alleviated with pain medications. Exam of the lumbar spine showed negative straight leg raise (SLR), tenderness, limited range with intact deep tendon reflexes (DTRs) 2+, 5/5 motor strength and intact sensation in all dermatomes of the lower extremities. The plan was to wait for an electromyography (EMG)/nerve conduction velocity (NCV) study findings for impairment ratings.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**The request for physical therapy for the lumbar spine, two (2) times a week for six (6) weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy Page(s): 474.

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

**Decision rationale:** Physical therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. There is unchanged chronic symptom complaints, clinical findings, and work status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. Submitted reports have no acute flare-up or specific physical limitations to support for physical therapy. The Chronic Pain Guidelines allow for 9-10 visits of physical therapy with fading of treatment to an independent self-directed home program. The employee has failed conservative treatment without physiologic evidence of tissue insult, neurological compromise, or red-flag findings to support treatment request. The request for physical therapy for the lumbar, two (2) times a weeks for six (6) weeks is not medically necessary and appropriate.