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| <b>Case Number:</b>   | CM13-0058810 |                              |            |
| <b>Date Assigned:</b> | 12/30/2013   | <b>Date of Injury:</b>       | 04/20/2012 |
| <b>Decision Date:</b> | 10/27/2014   | <b>UR Denial Date:</b>       | 11/18/2013 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 11/27/2013 |

### 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 Anesthesiology, has a subspecialty in Pain Management 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:

According to the records made available for review, this is a 47-year-old female with a 4/20/12 date of injury. At the time (11/14/13) of the request for authorization for physical therapy twice a week for three weeks and CT myelogram of the lumbar spine, there is documentation of subjective (low back pain that radiates down her right leg all the way down to her foot with numbness and tingling and sometimes weakness in the right foot) and objective (tenderness to palpation noted in the lower lumbar region, lumbar range of motion is limited, mild weakness of 4+/5 in the right anterior tibialis and gastrocnemius, sensation to pinprick is diminished in the right L4, L5, and S1 dermatomes) findings, imaging findings (CT of the lumbar spine (8/29/13) report revealed postoperative changes. There is horizontally oriented thin 2 mm high lucency present through the mid section of the interbody fusion device; MRI lumbar spine (8/29/13) report revealed postoperative changes status post anterior and posterior instrumented L5-S1 interbody fusion; X-rays (11/14/13) revealed difficult to assess whether there is a solid fusion at L5-S1. There are some areas of lucency still seen between the inferior endplate of L5 and the interbody graft), current diagnoses (chronic intractable axial lower back pain, bilateral upper buttock pain, lytic spondylolisthesis Grade I/II at L5-S1, and rule out lumbar instability), and treatment to date (physical therapy). Regarding physical therapy twice a week for three weeks, the number of physical therapy sessions completed to date cannot be determined. In addition, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services with physical therapy completed to date. Regarding CT myelogram of the lumbar spine, there is no documentation of preoperative planning and MRI is unavailable, contraindicated, or inconclusive.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy twice a week for three weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Physical therapy

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines support a brief course of physical medicine for patients with chronic pain not to exceed 10 visits over 4-8 weeks with allowance for fading of treatment frequency, with transition to an active self-directed program of independent home physical medicine/therapeutic exercise. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG recommends a limited course of physical therapy for patients with a diagnosis of lumbago/backache not to exceed 9 visits over 8 weeks. ODG also notes 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 a negative direction (prior to continuing with the physical therapy) and when treatment requests exceeds guideline recommendations, the physician must provide a statement of exceptional factors to justify going outside of guideline parameters. Within the medical information available for review, there is documentation of diagnoses of chronic intractable axial lower back pain, bilateral upper buttock pain, lytic spondylolisthesis Grade I/II at L5-S1, and rule out lumbar instability. In addition, there is documentation of previous physical therapy completed to date. However, the number of physical therapy sessions completed to date cannot be determined. In addition, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services with physical therapy completed to date. Furthermore, if the number of physical therapy sessions completed to date exceeds guidelines, there is no documentation of a statement of exceptional factors to justify going outside of guideline parameters. Therefore, based on guidelines and a review of the evidence, the request for physical therapy twice a week for three weeks is not medically necessary.

**CT myelogram of the lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Myelography

**Decision rationale:** MTUS reference to ACOEM identifies documentation of preoperative planning and MRI is not available, as criteria necessary to support the medical necessity of myelography. ODG identifies that myelography is recommended when MRI is unavailable, contraindicated (e.g. metallic foreign body), or inconclusive. Within the medical information available for review, there is documentation of diagnoses of chronic intractable axial lower back pain, bilateral upper buttock pain, lytic spondylolisthesis Grade I/II at L5-S1, and rule out lumbar instability. However, there is no documentation of preoperative planning and MRI is unavailable, contraindicated, or inconclusive. Therefore, based on guidelines and a review of the evidence, the request for CT myelogram of the lumbar spine is not medically necessary.