

<b>Case Number:</b>	CM14-0000494		
<b>Date Assigned:</b>	01/17/2014	<b>Date of Injury:</b>	10/11/2011
<b>Decision Date:</b>	06/09/2014	<b>UR Denial Date:</b>	12/19/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/02/2014

### 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 Physical Medicine and Rehabilitation, has a subspecialty in Sports Medicine 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 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:

The injured worker is a 56 year old female with a reported date of injury on 10/21/2011. The worker was injured while getting a child out of the van; she twisted her back and immediately felt pain. The injured worker previously received more than 12 sessions of physical therapy, in addition to acupuncture and chiropractic therapy. The physical therapy note dated 09/11/2013 noted range of motion was assessed; however, the numerical values were not provided. On that date the injured worker complained of 8/10 pain to the thoracic spine and the ilium. The progress note dated 01/06/2014 noted the injured worker was to undergo 2 more physical therapy sessions and the provider was requesting 6 additional sessions. The request for authorization was not submitted with the medical records. The request is for outpatient physical therapy three times a week for two weeks to the throacic and lumbar spine.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **OUTPATIENT PHYSICAL THERAPY THREE TIMES A WEEK FOR TWO WEEKS TO THE THORACIC AND LUMBAR SPINE: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine.

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

**Decision rationale:** The request for outpatient physical therapy three times a week for two weeks to the thoracic and lumbar spine is non-certified. The injured worker received over 12 sessions of physical therapy during 2013 as well as sessions of acupuncture and chiropractic care. The California Chronic Pain Medical Treatment guidelines state active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Injured workers are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. The guidelines recommend 9-10 visits over 8 weeks. The injured worker has received over 12 sessions of physical therapy due to flare-ups for her condition; the number of sessions requested would exceed the guideline recommendations. The efficacy of the prior physical therapy was unclear. Additionally, it was unclear if the injured worker had functional deficits for which physical therapy would be needed. Therefore, the request is not medically necessary.