

<b>Case Number:</b>	CM14-0007077		
<b>Date Assigned:</b>	02/07/2014	<b>Date of Injury:</b>	06/13/2008
<b>Decision Date:</b>	07/11/2014	<b>UR Denial Date:</b>	01/06/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/15/2014

### 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 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:

Patient is a 42-year-old-male who has submitted a claim for multilevel intervertebral cervical disc syndrome, multilevel intervertebral lumbar disc syndrome associated with an industrial injury date of 6/13/08. Medical records from 2012-2013 were reviewed which revealed persistent neck pain that radiated to his bilateral upper extremities. Low back pain was noted which radiated to his left lower extremity. Increase activities worsened pain. He had difficulty with activities of self-care and personal hygiene as a result of increased pain on the neck and lower back. Physical examination of cervical spine showed limited range of motion in all directions secondary to pain. Mild tenderness was elicited over the cervical spinous processes and interspaces from C3-C7 bilaterally. Hand grip strength was 4/5 on the left and 5/5 on the right. Examination of the lumbar spine showed limited range of motion in all directions secondary to pain. Tenderness was noted over lumbar spinous processes and interspaces from L3-S1. Lower extremity reflexes were present. Right straight leg raise in the sitting position was positive at 90 degrees with a negative Lasegue sign. Left straight leg raise test in sitting position was positive at 90 degrees with a negative Lasegue sign. EMG/NCS of lumbar spine and lower extremities done on 4/11/13 showed chronic denervation of bilateral flexor digitorum brevis muscles and axonal neuropathy. NCS was normal. Treatment to date has included, lumbar epidural injections. Medications taken were Robaxin, Relafen, Prilosec, Tramadol-Baclofen and Flurbiprofen-Gabapentin-Lidocaine. Utilization review from 1/6/14 modified the request for physical therapy of the cervical region three times a week for 4 weeks and lumbar regions three times a week for 4 weeks to 3 visits. No modification reason was made available from the documents submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PHYSICAL THERAPY FOR THE CERVICAL REGIONS (3 TIMES 4): Overturned**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back Chapter, Physical Therapy Section.

**Decision rationale:** As stated on pages 98-99 of the Chronic Pain Medical Treatment Guidelines, physical medicine is recommended and that given frequency should be tapered and transition into a self-directed home program. ODG, Neck and Upper Back Chapter, Physical therapy section also recommends physical therapy for cervical intervertebral disc syndrome for at least 10-12 visits over 8 weeks. This is to avoid debilitation and further restriction of motion. In this case, patient's diagnosis was intervertebral cervical disc syndrome. Progress report dated 11/25/13 mentioned that he has limited range of motion of the cervical spine secondary to pain. In addition, he is having difficulty performing his activities of daily living because of pain in the cervical area. Physical therapy would be beneficial to increase range of motion of the cervical spine and avoid further debilitation. Medical necessity has been established. Therefore, the request for Physical Therapy for the cervical regions (3 times 4) is medically necessary.

**PHYSICAL THERAPY FOR THE LUMBAR REGIONS (3 TIMES 4): Overturned**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Physical Therapy Section.

**Decision rationale:** As stated on pages 98-99 of the Chronic Pain Medical Treatment Guidelines, physical medicine is recommended and that given frequency should be tapered and transition into a self-directed home program. ODG, Low Back Chapter, Physical therapy section also recommends 10 visits over 8 weeks of physical therapy for lumbar disc disorder. This is to provide stretching and muscle-strengthening exercises to restore functional status and decrease pain. In this case, patient's diagnosis was intervertebral lumbar disc disorder. Progress report dated 1/23/14 mentioned that he completed 3 sessions of physical therapy. This helped him to decrease low back pain level to 5/10. Functional improvement was noted. Physical therapy would be beneficial to the patient to reduce pain. Furthermore, physical therapy would help restore functional status of the patient through stretching and muscle strengthening exercises. Medical necessity has been established. Therefore, the request for Physical Therapy for the lumbar regions (3 times 4) is medically necessary.

