

<b>Case Number:</b>	CM14-0108725		
<b>Date Assigned:</b>	08/01/2014	<b>Date of Injury:</b>	04/16/2011
<b>Decision Date:</b>	09/17/2014	<b>UR Denial Date:</b>	06/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/14/2014

### 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 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 patient is a 47-year-old female who was injured on 04/16/2011. The mechanism of injury is unknown. Past medical treatment included Flexeril, Percocet, Mobic and Pristiq. Her conservative treatment included physical therapy. The primary diagnosis is chronic back pain. The 8/15/2013 MRI of the lumbar spine revealed L5-S1 posterior decompression; interval L4-5 and L5-1 interbody fusion insert placement; interval posterior instrumentation at L4-5 and L5-S1; small left L2-3 disc protrusion and associated annular fissure contacts the left L2 nerve root correlate for corresponding radiculopathy; and right T11-12 posterior lateral disc protrusion incompletely imaged but without interval change. An Emergency Department report dated 01/9/2014 states the patient presented with complaints of chronic back pain. She reported degenerative disc disease in her T-spine and L-spine. On exam, she has normal range of motion of the lumbar spine without tenderness. Patellar reflex was slightly high but present. There is no costovertebral tenderness. There is no swelling or ecchymosis. Straight leg raising is negative. Diagnoses are back pain, lumbar degenerative disc disease, disc herniation, and sciatica. According to the Primary Treating Physician's (PTP) PR-2 dated 5/22/2014, the patient presents for routine followup for chronic back pain. Her back pops, pain is tolerable, rated 4/10 with medication, and 8/10 without medication. Medications are Percocet and Oxycontin. She requests medication refills and physical therapy. Physical examination findings are continuing pain, previous surgical intervention, paraspinal spasms, and she walks with support. Treatment plan is to refill medications as needed and request PT 3x/week for 4 weeks. Prior Utilization Review dated 06/18/2014 states the request for Physical Therapy to the back for 12 sessions is denied as medical necessity has not been established.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy to the back Qty: 12: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

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

**Decision rationale:** The patient is more than 3 years postdate of injury, and past medical care has included supervised physical therapy to the back. The patient's response to prior PT is not documented. There is lack of evidence to support the patient has obtained notable objective functional improvement with rendered PT. The evaluation on 1/19/2014 revealed an essentially negative examination with normal range of motion of the lumbar spine without tenderness, no costovertebral tenderness, no swelling or ecchymosis and negative straight leg raising. The 5/22/2014 PTP PR-2 documents no notable change in complaints or objective findings in comparison to the prior PR-2s. The medical records do not establish she has presented with an exacerbation/flare-up or re-injury as to support a return to supervised therapy. There is no mention of this patient utilizing a Home Exercise Program and self-care for management of her condition is not evident. However, the guidelines state patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. At this juncture, it is reasonable that the patient should be well versed in an independently applied Home Exercise Program of stretching, strengthening and therapeutic exercises, which should be utilized to manage her residual complaints and help maintain function. The medical necessity for physical therapy has not been established.