

<b>Case Number:</b>	CM14-0135616		
<b>Date Assigned:</b>	08/29/2014	<b>Date of Injury:</b>	09/02/2010
<b>Decision Date:</b>	10/08/2014	<b>UR Denial Date:</b>	08/06/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/22/2014

### 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 Internal Medicine and Pulmonary Diseases, 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:

The injured worker is 57-year-old female who reported an injury on 09/02/2010. The injury reportedly occurred when she was putting a wallboard up while standing on her toes. When she put her toes back down, she did so very hard causing a sharp pain from the bottom of her left leg to her waist. Her diagnosis was listed as sprain to the lumbar region. The past treatments include medications which did not provide her any significant relief including greater than six weeks of NSAIDs, injections, physical therapy which did not provide significant relief, and a TENS unit that did not provide her any relief. The diagnostic studies included an unofficial MRI of the lumbar spine dated 05/21/2014, which was noted to reveal severe central spinal stenosis at L3-L4 and L4-L5. There were no relevant surgeries noted in the medical record. On 06/27/2014, the injured worker complained of left paraspinal lumbosacral low back pain with radiation into her bilateral lower extremities, and into the soles of her feet. She reported her low back pain as occasional, but was unable to rate this pain. She reported her left leg pain is constant and rated it an 8-9/10 without medications and a 0/10 with medications. Her right leg pain was rated a 9/10 and reported as constant. She stated that she get some relief with the pain medications but has had several occasions where she has felt "paralyzed for minutes." Upon physical examination, the injured worker was noted to have painful joints, swelling of joints, stiffness of joints and muscle spasms. There was no significant decrease in motor strength with the exemption of a rated 4+/5 to the iliopsoas and quadriceps, no decrease in sensation noted, with a decrease in the lumbar range of motion. Her lumbar flexion was limited at 30 degrees and the sacral extension was limited to 10 degrees. The medications were listed as Hydrochlorine, Naprosyn, Bizafibrato, Metformin, and Pravastatin. The treatment plan was a recommendation for a trial of Gabapentin and possibly surgery depending on the severity of her stenosis. The request was for outpatient

therapy. The rationale for the request was not provided. The request for authorization form was not submitted for review.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Outpatient Therapy (Physical Therapy) two (2) times a week over six (6) weeks:** Upheld

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

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

**Decision rationale:** The request for outpatient therapy (PT) two times a week over six weeks is not medically necessary. The California MTUS Guidelines may recommend physical therapy based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients 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. Treatment is recommended for up to ten visits over 8 weeks. The injured worker was noted to have pain that she reported as an 8-9/10 to her leg and a 9/10 to her right leg pain. She reported a pain of 0/10 with medications. The documentation did not provided sufficient evidence of objective functional deficits or the number of physical therapy sessions previously completed. Although she was noted to have a decrease in lumbar range of motion and some weakness, it was not indicated that she was unable to complete activities of daily living. There was no documentation with evidence of functional gains or a decrease in pain with the previous physical therapy the injured worker completed. In the absence of sufficient documentation with evidence of objective functional gains, and the number of completed physical therapy, the request is not supported at this time. Therefore, the request is not medically necessary.