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| <b>Case Number:</b>   | CM14-0152954 |                              |            |
| <b>Date Assigned:</b> | 09/24/2014   | <b>Date of Injury:</b>       | 05/24/2011 |
| <b>Decision Date:</b> | 10/24/2014   | <b>UR Denial Date:</b>       | 09/16/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 09/19/2014 |

### 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 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:

This injured worker sustained an injury on 5/24/11 while employed by [REDACTED]. Request(s) under consideration include 8 Physical Therapy Sessions and 1 Pair of Shoes Orthotics. Diagnoses include lumbosacral disc degeneration; chronic pain; lumbar facet arthropathy; lumbar radiculopathy; medication related dyspepsia; obesity s/p gastric bypass. Conservative care has included medications, physical therapy (11 visits with reported decreased pain, increased function, and improved life), and modified activities/rest. The injured worker continues to treat for chronic neck and low back pain. Report of 9/4/14 from the provider noted the injured worker with neck pain radiating to left upper extremity; low back pain radiating to bilateral lower extremity; left hip pain; headaches; and coccyx pain rated at 6/10 with medications and 8/10 without. Overall, the injured worker reported no change from previous visit. Exam showed lumbar tenderness and spasm at L4-S1; decreased range with increased pain on flexion and extension; diffuse decreased sensation and motor strength of L4/5 left dermatome; positive SLR. The request(s) for 8 Physical Therapy Sessions and 1 Pair of Shoes Orthotics were non-certified on 9/16/14 citing guidelines criteria and lack of medical necessity.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**8 Physical Therapy Sessions:** 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 THERAPY Page(s): 98-99.

**Decision rationale:** Physical therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. However, there is no clear measurable evidence of progress with the 11 physical therapy treatment visits already rendered including milestones of increased ROM, strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints, clinical findings, and work status. There is no evidence documenting functional baseline with clear goals to be reached and the injured worker striving to reach those goals. The Chronic Pain Guidelines allow for 9-10 visits of physical therapy with fading of treatment to an independent self-directed home program. It appears the employee has received significant therapy sessions without demonstrated evidence of functional improvement to allow for additional therapy treatments. There is no report of acute flare-up, new injuries, or change in symptom or clinical findings to support for formal physical therapy in an injured worker that has been instructed on a home exercise program for this chronic injury. Submitted reports have not adequately demonstrated the indication to support further physical therapy when prior treatment rendered has not resulted in any functional benefit. The 8 Physical Therapy Sessions is not medically necessary.

**1 Pair of Shoes Orthotics:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 371.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Ankle & Foot, Bracing/ Immobilization, pages 10-11: Not recommended in the absence of a clearly unstable joint

**Decision rationale:** Per ODG, rigid orthotics (full-shoe-length inserts made to realign within the foot and from foot to leg) may reduce pain experienced during walking and may reduce more global measures of pain and disability for patients with plantar fasciitis and metatarsalgia. Additionally, shoe modification may be an option in the conservative care for ankle fusion, non- or malunion of fracture, or traumatic arthritis with objective findings on imaging and clinical exam not presented here with diagnoses relating to lumbar spine disorders. The 1 Pair of Shoes Orthotics is not medically necessary.