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| <b>Case Number:</b>   | CM14-0167209 |                              |            |
| <b>Date Assigned:</b> | 10/14/2014   | <b>Date of Injury:</b>       | 04/28/2013 |
| <b>Decision Date:</b> | 11/17/2014   | <b>UR Denial Date:</b>       | 09/12/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 10/10/2014 |

### 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 48 year-old patient sustained an injury on 4/28/13 while employed by [REDACTED]. Request(s) under consideration include Physical therapy 1 time a week for 4 weeks, post epidural injection. Diagnoses include lumbar sprain/ strain/ radiculopathy; Neck sprain/ strain. Report of 8/20/14 from the pain management provider noted the patient with ongoing chronic neck and lower back pain. Exam showed tenderness at paracervical musculature, right trapezium; no spasm or trigger points evident; positive Spurling's test caused radicular pain to the right upper extremity with decreased sensation along dermatomal pattern. Diagnoses list cervical disc herniation/ radiculopathy; lumbar disc herniation/ radiculopathy. Treatment plan was to schedule cervical epidural steroid injection with PT of 4 sessions post CESI. The request(s) for Physical therapy 1 time a week for 4 weeks, post epidural injection was modified for 2 sessions on 9/10/14 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:

**Physical therapy 1 time a week for 4 weeks, post epidural injection:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Neck and Upper Back Chapter

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy, pages , Physical Medicine Guidelines - Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Physical Therapy post-ESI, page 474

**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 PT treatment 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 patient striving to reach those goals. The Chronic Pain Guidelines allow for 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 PT in a patient 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 patient has planned ESI with therapy request. Per current literature, guidelines allow for a maximum of 2 therapy visits to reinforce the home exercise program post ESI which has recently been certified. There are no reported complications or extenuating circumstances to support further PT post injection outside guidelines criteria. The Physical therapy 1 time a week for 4 weeks, post epidural injection is not medically necessary and appropriate.