

<b>Case Number:</b>	CM13-0063310		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	02/29/2012
<b>Decision Date:</b>	11/06/2015	<b>UR Denial Date:</b>	11/06/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/09/2013

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 55 year-old female sustained an injury on 2/29/12 while employed. Request under consideration include additional physical therapy QTY: 16.00 (2 times a week for 8 weeks). Report of 10/17/13 from the provider noted patient with complaints of left low back pain rated at 8/10, increased with activities of daily living. Exam showed full motor strengthening lower extremities with normal sensation; negative SLR bilaterally; tenderness over the sacrum and in the lumbar paraspinal muscles with ongoing spasms. Report of 10/23/13 noted low back pain rated at 6/10 with exam findings of moderate restrictions of paravertebral and leg muscles with 4/5 motor strength and tenderness to palpation over the paravertebral muscles. Report of 10/25/13 had no subjective or exam findings noted. Diagnoses include degenerative disc disease; non-specific pain. Medications list Oxycontin, Percocet, Valium, Vitamins, Gabapentin, and Wellbutrin. Request for additional physical therapy 16 visits was non-certified on 11/6/13 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 (additional PT- 2x week for 8 weeks) Quantity: 16: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines Low Back, Physical therapy.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

**Decision rationale:** This 55 year-old female sustained an injury on 2/29/12 while employed. Request under consideration include additional physical therapy qty: 16.00 (2 times a week for 8 weeks). Report of 10/17/13 from the provider noted patient with complaints of left low back pain rated at 8/10, increased with activities of daily living. Exam showed full motor strengthening lower extremities with normal sensation; negative SLR bilaterally; tenderness over the sacrum and in the lumbar paraspinal muscles with ongoing spasms. Report of 10/23/13 noted low back pain rated at 6/10 with exam findings of moderate restrictions of paravertebral and leg muscles with 4/5 motor strength and tenderness to palpation over the paravertebral muscles. Report of 10/25/13 had no subjective or exam findings noted. Diagnoses include degenerative disc disease; non-specific pain. Medications list Oxycontin, Percocet, Valium, Vitamins, Gabapentin, and Wellbutrin. 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 9-10 visits of physical therapy with fading of treatment to an independent self-directed home program. It appears the employee has received at least - therapy sessions per reports by physical therapist and clinic notes without demonstrated evidence of functional improvement to allow for additional therapy treatments. There is no report of acute flare-up and the patient has been instructed on a home exercise program for this 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 ADDITIONAL PHYSICAL THERAPY QTY: 16.00 (2 TIMES A WEEK FOR 8 WEEKS) is not medically necessary and appropriate.