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| <b>Case Number:</b>   | CM14-0206719 |                              |            |
| <b>Date Assigned:</b> | 12/18/2014   | <b>Date of Injury:</b>       | 10/29/2012 |
| <b>Decision Date:</b> | 02/10/2015   | <b>UR Denial Date:</b>       | 11/20/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 12/10/2014 |

### 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 Family Practice and is licensed to practice in North Carolina. 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 56-year-old with a reported date of injury of 10/29/2012. The patient has the diagnoses of lumbar sprain/strain, lumbosacral disc bulge, lumbosacral radiculopathy, sacroiliac dysfunction, adjustment reaction, chronic pain syndrome, lumbar facet arthropathy, scoliosis and insomnia. Previous treatment modalities have included TENs unit and physiotherapy. Per the progress notes from the requesting physician dated 10/30/2014, the patient had complaints of increased lower extremity and low back pain. The physical exam noted lumbar spine and SI joint tenderness with trigger points and spasm, positive straight leg raise test on the left, positive bilateral facet loading test and no sensory deficits. Treatment plan recommendations included urine drug screen, physical therapy and continuation of medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy 3x4 weeks- bilateral low back arena:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** The California chronic pain medical treatment guidelines section on physical medicine states: Recommended as indicated below. Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during therehabilitation process. Active therapy is 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. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatmentprocess in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. (Colorado, 2002) (Airaksinen, 2006) Patient-specific hand therapy is very important in reducing swelling, decreasing pain, and improving range of motion in CRPS. (Li, 2005) The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passivetreatments is associated with substantially better clinical outcomes. In a large case series of patients with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment. (Fritz, 2007)Physical Medicine Guidelines: Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine.Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeksNeuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2): 8-10 visits over 4 weeksReflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks The California MTUS does recommend physical therapy as a treatment option for chronic pain. However the amount of sessions requested is in excess of the guideline recommendations. Also, the patient has already completed a course of physical therapy previously per the progress notes. Guidelines recommend conversion to home exercise programs after a certain amount of sessions. Since the request is in excess of the amount specified in the California MTUS, the request is not certified.