

<b>Case Number:</b>	CM15-0007010		
<b>Date Assigned:</b>	01/26/2015	<b>Date of Injury:</b>	11/20/2012
<b>Decision Date:</b>	03/18/2015	<b>UR Denial Date:</b>	12/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/13/2015

### 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:

The injured worker is a 54 year old female, who sustained an industrial injury on November 20, 2012. She has reported lower back pain with radiation to the right leg. The diagnoses have included lumbar spondylolisthesis, and right lower extremity radiculopathy. Treatment to date has included medications, physical therapy, H-wave unit trial, cortisone injections, nerve root block, lower back surgery, and imaging studies. Currently, the injured worker complains of continued lower back pain with radiation and numbness to the right leg. The treating physician is requesting additional physical therapy twice weekly for an unspecified duration of time. On December 24, 2014 Utilization Review non-certified the request for additional physical therapy noting the lack of documentation to support the medical necessity of the service. The MTUS chronic pain medical treatment guidelines and ODG were cited in the decision.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Additional Physical Therapy, 2 times weekly, unspecified duration, Lumbar Spine, per 12/02/14 exam note:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back (updated 11/21/14), Physical Therapy (PT)

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

**Decision rationale:** This patient presents with low back pain radiating to the buttocks, right hip, and outer thigh with numbness down the calf and foot. The patient is status post right L5-S1 nerve root block from 08/25/2014. The treater is requesting ADDITIONAL PHYSICAL THERAPY 2 TIMES WEEKLY, UNSPECIFIED DURATION, LUMBAR SPINE, PER 12/02/2014 EXAM NOTE. The RFA dated 12/02/2014 notes a request for authorization for additional physical therapy for the lumbar spine 2 times a week. The patient's date of injury is from 11/20/2012 and her current work status is TTD. The MTUS Guidelines page 98 and 99 on physical medicine recommend 8 to 10 visits for myalgia, myositis, and neuralgia type symptoms. The records do not show any physical therapy reports. The 12/02/2014 report notes, the patient has completed all of the authorized sessions of physiotherapy for the lumbar spine. There is no documentation of functional improvement or reduction of pain while utilizing physical therapy. The treater is requesting additional physical therapy to focus on stretching, modalities, range of motion, and strengthening. In this case, the patient has completed an unknown number of physical therapy sessions with no reports of benefit. MTUS page 8 on chronic pain requires satisfactory response to treatment including increased levels of function, decreased pain, or improved quality of life. Given the lack of functional improvement while utilizing this modality, the request is not warranted. Furthermore, the request for 2 times weekly of physical therapy for an unlimited duration is not supported by the guidelines. The request IS NOT medically necessary.