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| <b>Case Number:</b>   | CM15-0143110 |                              |            |
| <b>Date Assigned:</b> | 08/04/2015   | <b>Date of Injury:</b>       | 03/09/2001 |
| <b>Decision Date:</b> | 09/02/2015   | <b>UR Denial Date:</b>       | 07/14/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 07/23/2015 |

### 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, Pain Management

### 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 74 year old female, who sustained an industrial injury on 03-09-2001. She has reported injury to the low back. The diagnoses have included chronic low back pain; lumbar radiculopathy; osteopenia; severe kyphosis of T10-T11 due to a compression fracture of T11; and status post interbody fusion T10-T11, on 06-03-2015. Treatment to date has included medications, diagnostics, bracing, front-wheeled walker, physical therapy, spinal cord stimulator implantation, and surgical intervention. Medications have included Naprosyn, Oxycodone, Dilaudid, Lyrica, Cymbalta, Soma, Diazepam, Gabapentin, and Tramadol. A progress report from the treating provider, dated 07-06-2015, documented an evaluation with the injured worker. The injured worker reported having had a fall and "heard a pop" in her lower back. Objective findings included status post-surgery; up in wheelchair; vital signs stable; she had an emergency room visit and saw orthopedist; had a CT (computed tomography) of the brain; she has bruising at the left temple; lungs are clear to auscultation bilaterally; positive bowel sounds; and there is no edema. The treatment plan has included continuation of rehabilitation. Request is being made for physical therapy 6 times per week for 3 weeks; occupational therapy 5 times per week for 3 weeks; and skilled nursing 3 weeks.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy 6 times per week for 3 weeks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Physical Therapy.

**Decision rationale:** Regarding the request for additional physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, there is documentation of completion of 128 prior PT and OT sessions, with documented improvement subjective pain. However, there is no documentation of functional improvement and no explanation of what remaining deficits that cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised therapy. Furthermore, the request exceeds the amount of PT recommended by the CA MTUS and, unfortunately, there is no provision for modification of the current request. In light of the above issues, the currently requested additional physical therapy is not medically necessary.

**Occupational therapy 5 times per week for 3 weeks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Physical Therapy.

**Decision rationale:** Regarding the request for additional occupational therapy, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, there is documentation of completion of 128 prior PT and OT sessions. However, there is no documentation of functional improvement and no explanation of what remaining deficits that cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised therapy. Furthermore, the request exceeds the amount of OT recommended by the CA MTUS and, unfortunately, there is no provision for modification of the current request. In light of the above issues, the currently requested additional occupational therapy is not medically necessary.

**Skilled nursing 3 weeks: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee and Leg Chapter, SNF.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Skilled Nursing Facility Care.

**Decision rationale:** Regarding the request for rehabilitation inpatient facility, California MTUS and ACOEM do not contain criteria for the use of skilled nursing facilities. The ODG Low Back Chapter states the following: "Recommended if necessary after hospitalization when the patient requires skilled nursing or skilled rehabilitation services, or both, on a 24-hour basis. For more information and Criteria for skilled nursing facility (SNF) care, see the Knee Chapter." The Knee Chapter of the ODG recommends the use of skilled nursing facilities if the patient has been hospitalized for at least 3 days for major multiple trauma or major surgery and was admitted to the skilled nursing facility within 30 days of discharge, if treatment for the above conditions has caused new functional limitations which preclude management with lower levels of care, and if those functional limitations cause an inability to ambulate more than 50 feet or perform activities of daily living. Additionally, skilled nursing admission would require that the patient needs skilled nursing or skilled rehabilitation services or both on a daily basis at least 5 days per week. The patient needs to benefit from and participate with at least 3 hours per day of physical therapy, occupational therapy, and or speech therapy. Additionally, ODG states that the facility must be a Medicare certified facility, and the treatment is precluded in lower levels of care. Within the information available for review, the patient has no diagnosis that qualifies her for the use of skilled nursing facility. Furthermore, the recently requested additional PT and OT are deemed not medically necessary. As such, the currently requested rehabilitation inpatient facility is not medically necessary.