

<b>Case Number:</b>	CM15-0145638		
<b>Date Assigned:</b>	08/06/2015	<b>Date of Injury:</b>	10/04/2010
<b>Decision Date:</b>	09/02/2015	<b>UR Denial Date:</b>	07/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/27/2015

### 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 60-year-old male who sustained an industrial injury on 10-4-10. The assessment is lumbago and lumbago sciatica due to displacement of lumbar intervertebral disc. Previous treatment includes physical therapy, home exercises, lumbar brace, medication, 2 epidural injections, 2 facet joint injections, removal of hardware and facet rhizotomies 5-18-15, L5-S1 transforaminal lumbar interbody fusion and axial lumbar interbody fusion 7-23-12. In a progress report dated 5-29-15, the treating physician notes he has had issues with mechanical back pain likely due to hardware, which was removed on 5-18-15. The injured worker reports there has been interval improvement of his prior sharp and stabbing pain in his buttock area. There is some residual surgical pain in his back. He continues to use the cane for support only. Current medications are Glipizide, Metformin HCL, Cephalexin, Diazepam, Oxycodone-Acetaminophen, and Meloxicam. Lumbar spine range of motion is limited secondary to pain. The treatment plan is for physical therapy for status post spinal decompression, status post hardware removal 5-18-15. The requested treatment is physical therapy 3 times a week for 3 months - lumbar.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy, 3 times a week for 3 months, lumbar: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy, pages 98-99.

**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 functional 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 Physical therapy, 3 times a week for 3 months, lumbar is not medically necessary and appropriate.