

<b>Case Number:</b>	CM15-0187252		
<b>Date Assigned:</b>	09/29/2015	<b>Date of Injury:</b>	04/06/2013
<b>Decision Date:</b>	11/06/2015	<b>UR Denial Date:</b>	09/17/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/23/2015

### 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: Massachusetts

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 56 year old male, who sustained an industrial injury on 4-6-2013. The medical records indicate that the injured worker is undergoing treatment for displacement of lumbar intervertebral disc without myelopathy. According to the progress report dated 9-3-2015, the injured worker presented with complaints of severe low back pain with radiation into the bilateral lower extremities, right greater than left. The pain is described as spasm-like, sharp, dull, and burning. On a subjective pain scale, he rates his pain 8 out of 10. The physical examination of the lumbar spine reveals restricted range of motion. The current medications are Cyclobenzaprine, Norflex, and Docuprene. The treating physician noted that the injured worker was not taking any analgesic medications due to side effects. Previous diagnostic studies include MRI of the lumbar spine and electrodiagnostic testing. Treatments to date include medication management, acupuncture, and epidural steroid injection. Work status is described as not permanent and stationary. Per notes, he may return to work with restriction of no lifting, pushing or pulling weights over 10 pounds, no repetitive bending, stooping or crawling. The original utilization review (9-17-2015) had non-certified a request for physical therapy sessions to the lumbar spine.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy for the Lumbar Spine 1-2 Times a Week for 6 Weeks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (1) Chronic pain, Physical medicine treatment. (2) Preface, Physical Therapy Guidelines.

**Decision rationale:** The claimant sustained a work injury in April 2013 and continues to be treated for low back pain with right lower extremity radicular symptoms. On 08/11/15 he underwent a two level right-sided transforaminal epidural injection. When seen, he was having ongoing severe right hip and low back pain. Pain was rated at 8/10. Physical examination findings included decreased lumbar spine range of motion. Medications were prescribed. Authorization for a back brace, surgical evaluation, and up to 12 sessions of physical therapy was requested. The claimant is being treated for chronic pain with no new injury. In terms of physical therapy treatment for chronic pain, guidelines recommend a six visit clinical trial with a formal reassessment prior to continuing therapy. In this case, the number of visits requested is in excess of that recommended or what might be needed to determine whether continuation of physical therapy was needed or likely to be effective. The request is not considered medically necessary.