

<b>Case Number:</b>	CM15-0192818		
<b>Date Assigned:</b>	10/07/2015	<b>Date of Injury:</b>	08/10/2009
<b>Decision Date:</b>	11/16/2015	<b>UR Denial Date:</b>	09/10/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/01/2015

### 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, Indiana, New York  
Certification(s)/Specialty: Internal Medicine

### 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 50 year old female who sustained an industrial injury on 08-10-2009. A review of the medical records indicated that the injured worker is undergoing treatment for lumbar radiculopathy and lumbar degenerative disc disease. The injured worker is status post laminectomy, microdiscectomy, lumbar decompression in 2010, L5-S1 laminotomy, decompression in 2012, and anterior lumbar interbody fusion on 04-08-2015. According to the treating physician's progress report on 07-30-2015, the injured worker continues to experience lower back and left leg pain. Examination noted an antalgic gait with full strength. There was reproducible pain over the left posterior superior iliac spine otherwise, examination was non-focal. Prior treatments have included diagnostic testing, surgery, multi-disciplinarian pain management care and medications. There was no discussion of post-operative physical therapy initiated. Current medications were listed as Oxycodone and Voltaren gel. The injured worker remains on temporary total disability (TTD). Treatment plan consists of continuing medications and the current request for physical therapy times 8 visits, 2-3 times a week for 4 weeks. On 09-10-2015 the Utilization Review determined the request for physical therapy times 8 visits, 2-3 times a week for 4 weeks was not medically necessary.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy times 8 visits, 2-3 times a week for 4 weeks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back section, Physical therapy.

**Decision rationale:** Pursuant and to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, physical therapy times 8 visits (2-3 times per week times 4 weeks) is not medically necessary. Patients should be formally assessed after a six visit clinical trial to see if the patient is moving in a positive direction, no direction or negative direction (prior to continuing with physical therapy). When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted. In this case, the injured worker's working diagnoses are lumbar radiculopathy; and lumbar degenerative disc disease. Date of injury is October 10, 2009. Request for authorization is September 1, 2015. According to a September 1, 2015 progress note, subjective complaints include low back pain that radiates to the left lower extremity. Medications include Oxycodone. Objectively, physical examination is unchanged from the prior examination. The total number of physical therapy sessions to date is unspecified. There is no documentation demonstrating objective functional improvement from prior physical therapy to date. There are no compelling clinical facts indicating additional physical therapy is clinically warranted. Additionally, the request for authorization indicates eight physical therapy sessions and the language in parenthesis provides a range of 8-12 physical therapy sessions. Based on clinical information the medical record, peer-reviewed evidence-based guidelines, no documentation with a specified number of physical therapy sessions, no documentation demonstrating objective functional improvement and no compelling clinical facts indicating additional physical therapy is warranted, physical therapy times 8 visits (2-3 times per week times 4 weeks) is not medically necessary.