

<b>Case Number:</b>	CM15-0195246		
<b>Date Assigned:</b>	10/09/2015	<b>Date of Injury:</b>	12/29/2014
<b>Decision Date:</b>	11/18/2015	<b>UR Denial Date:</b>	09/18/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/05/2015

### 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 40 year old female, who sustained an industrial injury on 12-29-2014. A review of the medical records indicates that the injured worker is undergoing treatment for unspecified backache, gastritis and gastroduodenitis without mention of hemorrhage, and depression. On 9-16-2015, the injured worker reported persistent low back pain with pain along the right low back-side of hip, radiating down the right leg with intermittent cramps in the right leg and some weakness and numbness in the right thigh, rating her pain as 7-8 out of 10 on the pain scale, unchanged since 7-15-2015 visit. The Treating Physician's report dated 9-16-2015, noted the injured worker was feeling discouraged as she was waiting for approval for her physical therapy and MRI. The injured worker was noted to feel depressed and discouraged, increasing her Celexa with some increased fatigue and not much improvement noted in her depression, feeling increasingly depressed due to her chronic pain. The injured worker's current medications were noted to include Norco, Cyclobenzaprine, Gabapentin, Omeprazole, Citalopram Hydrobromide, Ibuprofen, and Docusate Sodium. The physical examination was noted to show no spinal tenderness, normal range of motion (ROM) of spine except flexion to 90 degrees with tenderness, and tenderness with side bend to left. The treatment plan was noted to include continued current medications except Celexa at bedtime, continue to be off work, and start Citalopram, with the Physician noting to try and see why the physical therapy and MRI had not yet been approved. On 7-15-2015, the Physician noted physical therapy ordered for the backache. On 5-19, 2015, the Physician noted the injured worker had to stop her physical therapy due to claim issue. On 4-1-2015, the injured worker was noted to have completed 12 sessions of

physical therapy with some improvement. A physical therapy re-evaluation note dated 3-19-2015, noted the start of care as 2-10-2015, having completed 12 visits, with the injured worker noted to report that she was benefiting a lot from therapy. She now has an improved ability to walk and has noticed that she has improved hip extension. The injured worker was noted to have improvement in home exercise program (HEP), increased lower extremity range of motion (ROM), increased strength, and improved transfers. However, the injured worker was noted to have continued ongoing moderate pain levels with unchanged VAS level, medication profile and work status not provided. The request for authorization dated 8-11-2015, requested physical therapy for the back 2x8. The Utilization Review (UR) dated 9-18-2015, non-certified the request for physical therapy for the back 2x8.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **PT Back 2x8: 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), Low Back chapter.

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

**Decision rationale:** Review indicates the patient was noted to have completed recent 12 sessions of PT in April 201 with the injured worker reporting improved ability to walk with increased strength and range. However, the injured worker was noted to have continued ongoing moderate pain levels with unchanged VAS level, medication profile and work status not provided. 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 PT Back 2x8 is not medically necessary and appropriate.