

<b>Case Number:</b>	CM15-0197717		
<b>Date Assigned:</b>	10/13/2015	<b>Date of Injury:</b>	10/25/2011
<b>Decision Date:</b>	11/20/2015	<b>UR Denial Date:</b>	09/10/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/07/2015

### 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 54 year old female injured worker suffered an industrial injury on 10-25-2011. The diagnoses included cervical disc displacement, lumbosacral disc degeneration and sprain of the foot. On 8-14-2015 the orthopedic provider noted ongoing cervical pain radiating to the bilateral shoulder and bilateral upper extremities. The lower back pain radiated to the lower extremities accompanied by stiffness, numbness and decreased motion along with left foot pain. She was currently wearing a lumbar brace for support. The pain limited her activities 100% of the time. On exam there was restricted range of motion to the cervical and lumbar spine with myospasms along with positive straight leg raise. A trigger point injection was administered at that visit. On 8-26-2015 the treating provider reported lumbar spine pain rated 8 to 9 out of 10 with decreased sensation from the cervical spine. Prior treatment included TENS unit, physical therapy, lumbar epidural steroid injections and medication. Request for Authorization date was 8-24-2015. The Utilization Review on 9-10-2015 determined non-certification for Physical therapy, lumbar spine, 2 times weekly for 5 weeks, 10 sessions.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy, lumbar spine, 2 times weekly for 5 weeks, 10 sessions: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Methods, and Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back, Lumbar & Thoracic (Acute & Chronic): Physical therapy (PT).

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

**Decision rationale:** Time-limited care plan with specific defined goals, assessment of functional benefit with modification of ongoing treatment based upon the patient's progress in meeting those goals and the provider's continued monitoring of successful outcome is stressed by MTUS guidelines. 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. Submitted reports have no acute flare-up or specific physical limitations to support for physical/ occupational therapy. The Chronic Pain Guidelines allow for 9-10 visits of therapy with fading of treatment to an independent self-directed home program. It is unclear how many PT sessions have been completed; however, the submitted reports have not identified clear specific functional improvement in ADLs, functional status, or decrease in medication and medical utilization nor have there been a change in neurological compromise or red-flag findings demonstrated from the formal physical therapy already rendered to support further treatment for this 2011 chronic injury. Submitted reports have also not adequately demonstrated the indication to support for excessive quantity of PT sessions without extenuating circumstances established beyond the guidelines. The physical therapy, lumbar spine, 2 times weekly for 5 weeks, 10 sessions is not medically necessary and appropriate.