

<b>Case Number:</b>	CM15-0021245		
<b>Date Assigned:</b>	02/10/2015	<b>Date of Injury:</b>	05/25/2011
<b>Decision Date:</b>	03/25/2015	<b>UR Denial Date:</b>	01/19/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/03/2015

### 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:

This 58 year old male sustained an industrial injury on 5/25/11. He subsequently reports chronic back pain. The injured worker has undergone lumbar fusion surgery. Treatment to date has included physical therapy, a back brace and Cyclobenzaprine, Elavil and Norco medications. An MRI dated 8/5/14 revealed abnormalities of the lumbar spine. On 1/19/15, Utilization Review non-certified a request for Physical therapy for the back, twice weekly for six weeks and a Repeat cervical MRI. The Physical therapy for the back, twice weekly for six weeks and a Repeat cervical MRI were denied based on MTUS, ACOEM and Chronic Pain guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy for the back, twice weekly for six weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177 - 179, Chronic Pain Treatment Guidelines Page(s): 98 - 99.

**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 for the back, twice weekly for six weeks is not medically necessary and appropriate.

**Repeat cervical MRI:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177 - 179, Chronic Pain Treatment Guidelines Page(s): 98 - 99.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): Chapter 8 Neck and Upper Back Disorders, Introductory Material, Special Studies and Diagnostic and Treatment Considerations, page(s) 171-171, 177-179.

**Decision rationale:** Per ACOEM Treatment Guidelines for the Neck and Upper Back Disorders, under Special Studies and Diagnostic and Treatment Considerations, states Criteria for ordering imaging studies include Emergence of a red flag; Physiologic evidence of tissue insult or neurologic dysfunction; Failure to progress in a strengthening program intended to avoid surgery; Clarification of the anatomy prior to an invasive procedure. Physiologic evidence may be in the form of definitive neurologic findings on physical examination and electrodiagnostic studies. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist; however, review of submitted medical reports, including report from providers have not adequately demonstrated the indication for repeating the MRI of the Cervical spine done previously on 8/24/11 showing degenerative disorder/ facet arthropathy/ canal stenosis and neural foraminal narrowing nor identify any specific acute change or progressive deterioration in clinical findings to support this imaging study. When the neurologic examination is less clear, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. The Repeat cervical MRI is not medically necessary and appropriate.