

<b>Case Number:</b>	CM14-0163790		
<b>Date Assigned:</b>	10/08/2014	<b>Date of Injury:</b>	12/28/2005
<b>Decision Date:</b>	11/04/2014	<b>UR Denial Date:</b>	09/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/06/2014

### 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. The expert reviewer is Board Certified in General Preventive Medicine and is licensed to practice in Indiana. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 employee is a 63 year old female with date of injury of 12/28/2005. A review of the medical records indicate that the patient is undergoing treatment for right hip arthroplasty and left hip degenerative arthritis and cervical, thoracic, and lumbar disc disease. Subjective complaints include continued pain in her hip bilaterally and in her lower back. Objective findings include reduced range of motion of the cervical, thoracic, and lumbar spines with pain upon palpation of the paravertebrals; reduced range of motion of hips bilaterally. Treatment has included Percocet, Imitrex, Cymbalta, Xanax, Zanaflex, and acupuncture. The utilization review dated 9/10/2014 non-certified 12 physical therapy sessions.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy 2 times a week for 6 weeks, total 12, for cervical and thoracic pain:**

Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315, Chronic Pain Treatment Guidelines Physical Therapy, Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Physical Therapy

**Decision rationale:** The California MTUS guidelines refer to physical medicine guidelines for physical therapy and recommends as follows: "Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." Additionally, ACOEM guidelines advise against passive modalities by a therapist unless exercises are to be carried out at home by patient. The ODG quantifies its recommendations with 10 visits over 8 weeks for lumbar sprains/strains and 9 visits over 8 weeks for unspecified backache/lumbago. ODG further states that a "six-visit clinical trial" of physical therapy with documented objective and subjective improvements should occur initially before additional sessions are to be warranted. The guidelines recommend that a 6 visit trial of physical therapy occur before additional sessions are warranted. She has already had acupuncture, but there was no documentation of objective and subjective improvements. As such, the request for 12 sessions of physiotherapy is not medically necessary.