

<b>Case Number:</b>	CM14-0081530		
<b>Date Assigned:</b>	07/18/2014	<b>Date of Injury:</b>	03/19/2002
<b>Decision Date:</b>	10/03/2014	<b>UR Denial Date:</b>	05/06/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/02/2014

### 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 Occupational Medicine and is licensed to practice in California. 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:

According to the records made available for review, this is a 45-year-old female with a 3/19/02 date of injury, status post left elbow surgery (undated), and status post Intradiscal Electrothermal Annuloplasty (undated). At the time (5/6/14) of the Decision for Physical Therapy once weekly for 6 weeks to the Lumbar Spine, there is documentation of subjective (pain in left wrist/hand, lumbar spine, left elbow, upper back, and right elbow) and objective (diminished sensation in left mid anterior thigh, left mid lateral calf, and left lateral ankle) findings, current diagnoses (lumbar spine strain with radiculopathy, thoracic spine strain, left wrist DeQuervain's syndrome, left carpal tunnel syndrome, right elbow lateral humeral epicondylitis, and right elbow ulnar neuropathy), and treatment to date (physical therapy, lumbar epidural steroid injection, and medications (including ongoing treatment with Soma)). The number of previous physical therapy sessions cannot be determined. There is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services as a result of physical therapy provided to date.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy once weekly for 6 weeks to the Lumbar Spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability guidelines

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Physical therapy Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines support a brief course of physical medicine for patients with chronic pain not to exceed 10 visits over 4-8 weeks with allowance for fading of treatment frequency, with transition to an active self-directed program of independent home physical medicine/therapeutic exercise. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG recommends a limited course of physical therapy for patients with a diagnosis of lumbar sprain and strains not to exceed 10 visits over 8 weeks. ODG also notes 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 a negative direction (prior to continuing with the physical therapy) and when treatment requests exceeds guideline recommendations, the physician must provide a statement of exceptional factors to justify going outside of guideline parameters. Within the medical information available for review, there is documentation of diagnoses of lumbar spine strain with radiculopathy, thoracic spine strain, left wrist DeQuervain's syndrome, left carpal tunnel syndrome, right elbow lateral humeral epicondylitis, and right elbow ulnar neuropathy. In addition, there is documentation of previous physical therapy. However, there is no documentation of the number of previous physical therapy treatments and, if the number of treatments have exceeded guidelines, remaining functional deficits that would be considered exceptional factors to justify exceeding guidelines. In addition, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services as a result of physical therapy provided to date. Therefore, based on guidelines and a review of the evidence, the request for Physical Therapy once weekly for 6 weeks to the Lumbar Spine is not medically necessary.