

<b>Case Number:</b>	CM14-0213123		
<b>Date Assigned:</b>	12/30/2014	<b>Date of Injury:</b>	12/10/1998
<b>Decision Date:</b>	02/25/2015	<b>UR Denial Date:</b>	12/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/19/2014

### 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. 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 & Rehabn

### 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 is a 62-year-old male with a 12/10/98 date of injury. The patient was seen on 11/20/14 with complaints of constant, moderate pain in the lumbosacral spine, which intermittently increased to moderately severe. The patient had no specific motor or sensory complaints. Exam findings of the lumbosacral spine revealed moderate spinous process tenderness of the lower lumbar spine area, muscle guarding, and negative left and right sciatic notch tenderness. The range of motion of the lumbar spine was: flexion 50 degrees and extension, left and right lateral side bending were 10 degrees. The neurological examination was normal and the SLR test was positive at 60 degrees bilaterally. The diagnosis is degenerative disc disease of the thoracic and lumbar spine. Treatment to date: work restrictions, TENS unit, PT, Voltaren gel, and medications. An adverse determination was received on 12/08/14 given that considering the patient's date of injury and amount of received treatment, there was a lack of documentation to suggest why a comprehensive home exercise program would be insufficient.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy 3x4 weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy Page(s): 98-99.

**Decision rationale:** CA MTUS stresses the importance of a time-limited treatment plan with clearly defined functional goals, frequent assessment and modification of the treatment plan based upon the patient's progress in meeting those goals, and monitoring from the treating physician regarding progress and continued benefit of treatment is paramount. However, there is a lack of documentation indicating subjective and objective functional gains from prior PT sessions. In addition, the number of completed PT visits was not available for the review. Lastly, given that the patient's injury was over 15 years ago it is not clear why the patient cannot transition to an independent home exercise program. Therefore, the request for Physical Therapy 3x4 weeks was not medically necessary.