

<b>Case Number:</b>	CM14-0214936		
<b>Date Assigned:</b>	01/07/2015	<b>Date of Injury:</b>	04/23/2013
<b>Decision Date:</b>	02/20/2015	<b>UR Denial Date:</b>	11/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/22/2014

### 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, Pain Management

### 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 34 year old female with a work related injury dated 04/23/2013 after a fall, which caused her to twist her right knee and ankle and injuring her neck and low back. According to a progress note dated 11/07/2014, the injured worker presented with complaints of low back pain and radiating pain into her left hip. Diagnoses included lumbar degenerative disc disease with disc-osteophyte complex and herniated nucleus pulposus impinging on left L4 and left L5 nerve roots, lumbar radiculopathy, myospasm and myofascial trigger points, acute left sacrolilitis, depression, fatigue and stress from pain and depression consistent with vitamin B12 deficiency, and fibromyalgia. Treatments have consisted of sacroiliac joint injection on 05/30/2014, which she reported over 50% improvement since her injection, along with medications. The treating physician noted to continue physical therapy as prescribed and consider further physical therapy and a home exercise program. Diagnostic testing included an MRI study of the thoracic spine which revealed mild biconvex curvature of the cervical spine and mild asymmetric disc space narrowing on the right at L1-2 without foraminal narrowing. A lumbar MRI study noted moderate broad based left paracentral foraminal disc-osteophyte ridge complex at L4-5 which results in moderate left foraminal stenosis with probably impingement of both exiting left L4 and descending L5 nerve roots. It also noted mild facet arthropathy at multiple levels. Work status is noted as modified work. On 11/24/2014, Utilization Review modified the request for 6 Additional Physical Therapy 2x/week for 3 weeks for the Lumbar Region as an outpatient to 1 Additional Physical Therapy two visits for the Lumbar Region as an outpatient between 11/18/2014 and 1/2/2015 citing Medical Treatment Utilization Schedule Chronic Pain

Guidelines. The Utilization Review physician stated that a progress note dated 11/11/2014 recommended further physical therapy and home exercise, however, there is no documentation regarding the amount or efficacy of prior physical therapy. Considering that some physical therapy has been accomplished, the request was partially medically necessary and modified to two visits of therapy for instruction in home exercise. Therefore, the Utilization Review decision was appealed for an Independent Medical Review.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Additional six (6) physical therapy sessions 2 times a week for 3 weeks for the lumbar region:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298, Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Page(s): Page 98 of 127. Decision based on Non-MTUS Citation Low Back Chapter, Physical Therapy

**Decision rationale:** Regarding the request for additional physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, there is documentation of completion of prior PT sessions, but there is no documentation of specific objective functional improvement with the previous sessions and remaining deficits that cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised therapy. Additionally, it is unclear how many physical therapy sessions the patient has undergone previously. In light of the above issues, the currently requested additional physical therapy is not medically necessary.