

<b>Case Number:</b>	CM14-0215730		
<b>Date Assigned:</b>	01/05/2015	<b>Date of Injury:</b>	01/07/1992
<b>Decision Date:</b>	02/24/2015	<b>UR Denial Date:</b>	12/12/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/23/2014

### 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, Indiana, New York  
 Certification(s)/Specialty: Internal Medicine

### 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 61 year old male sustained a work related injury on 1/7/1992. The mechanism of injury was reported to be injury from the seat collapsing in his truck. The current diagnoses are disc disorder of the lumbar spine and congenital spondylolysis of the lumbosacral region. According to the progress report dated 12/8/2014, the injured workers chief complaints were low back pain with radiating pain into the lateral aspect of right leg, right thigh, left thigh, left testicle, left groin, lower abdomen, upper abdomen and right foot. Pain was described as severe numbness. Associated symptoms included stiffness and spasms of the low back. The physical examination of the lumbar spine revealed positive spasm and rigidity. There was tenderness of the paraspinal muscles, spinous processes, and sacroiliac joint. Range of motion and muscle strength was decreased. On this date, the treating physician prescribed 12 physical therapy sessions of the lumbar spine, which is now under review. The physical therapy was prescribed specifically to increase strength, range of motion, and flexibility. In addition to physical therapy, the treatment plan included referral to pain management, back brace, and follow up appointment in one month. According to the Utilization Review, 12 previous physical therapy sessions were authorized around May 2014, but there were no reports of the specific date of service or results. When physical therapy was prescribed work status was light duty. Restrictions were to avoid bending, climbing, and twisting activities. On 12/12/2014, Utilization Review had non-certified a prescription for 12 physical therapy sessions of the lumbar spine. The physical therapy was non-certified based on no documentation of response to previous physical therapy sessions. The California MTUS Chronic pain Medical Treatment Guidelines were cited.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy 3-4 for the lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98-99. Decision based on Non-MTUS Citation Neck Section, Physical therapy

**Decision rationale:** Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, physical therapy three times a week for four weeks to the cervical spine is not medically necessary. 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 negative direction (prior to continuing with physical therapy). When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted. The guidelines enumerate the frequency and duration of physical therapy based on the injury sustained. In this case, the injured worker's working diagnoses are disk disorder of the lumbar spine; and congenital spondylosis of the lumbosacral region. The documentation in the medical record, according to the utilization review, indicates 12 sessions of physical therapy authorized in May 2014. The medical record did not contain physical therapy progress notes. There was no documentation of objective functional improvement with respect to prior physical therapy. Additionally, there was no evidence the injured worker was engaged in a home exercise program. There were no compelling facts in the medical record indicating additional physical therapy over the guideline allowance was indicated. Consequently, absent compelling clinical documentation to support additional physical therapy and evidence of objective functional improvement, physical therapy three times a week for four weeks to the cervical spine is not medically necessary.