

<b>Case Number:</b>	CM15-0017567		
<b>Date Assigned:</b>	02/05/2015	<b>Date of Injury:</b>	05/27/2009
<b>Decision Date:</b>	03/23/2015	<b>UR Denial Date:</b>	01/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/29/2015

### 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: TR, California, Virginia

Certification(s)/Specialty: Preventive Medicine, Occupational 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:

The injured worker is a 52 year old male who sustained a work related injury on May 27, 2009, after lifting a 400 pound module with a forklift. He initially complained of back pain with numbness in the right leg and foot at the time of injury. He subsequently underwent a diskectomy and spinal fusion surgery. Treatments have also included physical therapy, anti-inflammatory drugs and pain medications. Diagnoses include lumbar radiculopathy, lumbar spondylosis and stenosis, chronic pain syndrome and depression. Most recently, in December 2014, the injured worker complained of pain in the lower back, left shoulder, thigh, left knee, calf and right foot. On January 15, 2015 a request for physical therapy twice a week for 6 weeks for the lumbar area and physical therapy for six visits for the left knee and left shoulder was non-certified by Utilization Review, noting California Medical Treatment Utilization Schedule Chronic Pain Guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy (PT) 2 x 6 for the lumbar area:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58-60.

**Decision rationale:** The MTUS Chronic Pain Management Guidelines (pg 58-59) indicate that manual therapy and manipulation are recommended as options in low back pain. With respect to therapeutic care, the MTUS recommends a trial of 6 visits over 2 weeks, with evidence of objective functional improvement allowing for up to 18 visits over 6-8 weeks. If the case is considered a recurrence/flare-up, the guidelines similarly indicate a need to evaluate treatment success. In either case, whether considered acute or recurrent, the patient needs to be evaluated for functional improvement prior to the completion of 12 visits in order to meet the standards outlined in the guidelines. Overall, it is quite possible the patient may benefit from conservative treatment with manual therapy at this time. However, early re-evaluation for efficacy of treatment/functional improvement is critical. The guidelines indicate a time to produce effect of 4-6 treatments, which provides a reasonable timeline by which to reassess the patient and ensure that education, counseling, and evaluation for functional improvement occur. In this case, the request for a total of 12 visits to physical therapy without a definitive plan to assess for added clinical benefit prior to completion of the entire course of therapy is not considered medically necessary.

**Physical therapy (PT) x 6 visits for the left knee and left shoulder:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Page(s): 58-60.

**Decision rationale:** The MTUS Chronic Pain Management Guidelines (pg 58-59) do not indicate that manual therapy and manipulation are recommended for treatment in chronic knee or shoulder pain. At this point the patient is over five years from the initial date of injury and with no objective evidence to indicate presence of an acute re-injury or exacerbation, the shoulder and knee pain are assumed to be chronic in nature. Without strong evidence for physical therapy being beneficial in chronic cases of knee and shoulder pain and with no formal objective plan to measure and evaluate functional improvement, medical necessity of physical therapy can not be justified as any greater than a home exercise program emphasizing education, independence, and the importance of on-going exercise.