

<b>Case Number:</b>	CM15-0126925		
<b>Date Assigned:</b>	07/13/2015	<b>Date of Injury:</b>	08/01/2000
<b>Decision Date:</b>	08/07/2015	<b>UR Denial Date:</b>	06/24/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/01/2015

### 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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 (IW) is a 57-year-old male who sustained an industrial injury on 08/01/2000. Diagnoses include displacement of lumbar spine disc without myelopathy and spinal stenosis of the lumbar region. Treatment to date has included medications, activity modifications, epidural injections, acupuncture and physical therapy. According to the report dated 6/2/15, the IW reported sharp lower back pain and left leg numbness to the calf and numbness in the dorsal left foot, which began within the previous two weeks. On examination, range of motion (ROM) of the lumbar spine was 35 degrees flexion, 10 degrees extension, with pain, and lateral bending 15/5 with left-sided pain. Neurological exam was normal for motor strength, sensation and deep tendon reflexes. There was thoracic and lumbar asymmetry noted on inspection, with left 5mm parathoraco-lumbar prominence. Lumbar spine MRI on 5/21/15 showed multilevel facet arthrosis, disc bulging and foraminal narrowing; some canal stenosis was present at L3-4 and L4-5. A request was made for physical therapy for the low back three times weekly for six weeks for active/passive ROM, flexion posture exercises with intermittent traction.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy for the low back 3X6:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy, pages 98-99.

**Decision rationale:** Physical therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. However, there is no clear measurable evidence of progress with the PT treatment already rendered including milestones of increased ROM, strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints, clinical findings, and functional status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. The Chronic Pain Guidelines allow for visits of physical therapy with fading of treatment to an independent self-directed home program. It appears the employee has received significant therapy sessions without demonstrated evidence of functional improvement to allow for additional therapy treatments. There is no report of acute flare-up, new injuries, or change in symptom or clinical findings to support for formal PT in a patient that has been instructed on a home exercise program for this chronic injury of 2000. Submitted reports have not adequately demonstrated the indication to support further physical therapy when prior treatment rendered has not resulted in any functional benefit. The Physical therapy for the low back 3X6 is not medically necessary and appropriate.