

<b>Case Number:</b>	CM15-0066435		
<b>Date Assigned:</b>	04/14/2015	<b>Date of Injury:</b>	06/21/2009
<b>Decision Date:</b>	05/13/2015	<b>UR Denial Date:</b>	03/23/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/07/2015

### 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, 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:

The injured worker is a 60 year old male who sustained a work related injury June 21, 2009. According to a secondary treating physician's orthopedic spine surgery progress report, dated March 2, 2015, the injured worker presented with worsening pain in the low thoracic spine bilaterally, adjacent to the incision of the prior spinal cord stimulator placement and subsequent removal. The mid-back pain radiates into the right buttocks. He also complains of neck pain with numbness and tingling down the left arm to the hand and fingers. He rates his symptoms 5/10 with medication and 7-8/10 without medication. Assessment is documented as depression; s/p removal of spinal cord stimulator; L4-S1 pseudoarthrosis; s/p L4-S1 posterior spinal instrumentation and fusion; regional pain syndrome, right lower extremity; failed back syndrome; thoracic strain; right sacroiliac joint dysfunction; left cervical radiculopathy, non-industrial. Treatment plan included obtaining x-rays thoracic and lumbar spine, requests for authorization of MRI's: thoracic and cervical spine, acupuncture trial, urine drug screen, and physiotherapy, two times a week for three weeks, thoracic and lumbar spine.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy 2 x a week for 3 weeks (thoracic/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 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 98-99 of 127. Decision based on Non-MTUS Citation ODG, Neck and Low Back Chapters, Physical Medicine.

**Decision rationale:** Regarding the request for physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course (10 sessions) 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 no documentation of specific objective functional improvement with any 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. In light of the above issues, the currently requested physical therapy is not medically necessary.