

<b>Case Number:</b>	CM15-0074026		
<b>Date Assigned:</b>	04/24/2015	<b>Date of Injury:</b>	10/10/2007
<b>Decision Date:</b>	06/11/2015	<b>UR Denial Date:</b>	04/07/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/17/2015

### 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, 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:

The injured worker is a 66 year old male with an industrial injury dated October 10, 2007. The injured worker diagnoses include lumbar/lumbosacral disc degeneration, lumbar disc disorder/myelopathy, lumbar region spinal stenosis, sciatica and sacroiliac (SI) ligament sprain/strain. He has been treated with X-ray of lumbar spine dated 10/10/2014, prescribed medications, physical therapy and periodic follow up visits. According to the progress note dated 3/25/2015, the injured worker reported lumbar spine pain. The injured worker also reported constant pain to left buttock with pain radiating down the posterior left leg with intermittent numbness to the left foot. Objective findings revealed tenderness in the left sacroiliac (SI) joints, left iliac shear and left posterior superior iliac spine. Decreased sensation in anterior lateral thigh and leg were also noted on examination. The treating physician prescribed services for physical therapy for lumbar spine for modalities, core and SI joint stabilization.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy 2 Times A Week for 4 Weeks Lumbar Spine: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Section, Physical Therapy.

**Decision rationale:** Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, physical therapy two times per week times four weeks for the lumbar 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. "There is no high-grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities such as traction, heat/cold applications, massage, diathermy, cutaneous laser treatment, ultrasound, transcutaneous electrical neurostimulation (TENS) units, and biofeedback." These palliative tools may be used on a trial basis but should be monitored closely. Emphasis should focus on functional restoration and return of patients to activities of normal daily living". In this case, the injured worker's working diagnoses are lumbar/lumbosacral disc degeneration; lumbar disc disorder/myelopathy; lumbar region spinal stenosis; sciatica; and sacroiliac ligament sprain/strain. The injured worker's status post lumbar fusion and has received extensive physical therapy through calendar years 2014 - 2015. On February 26, 2015, an additional request for additional physical therapy was modified to #4. The treatment plan states the treating provider is requesting additional physical therapy with modalities. The treating provider does not specify what modalities are to be used. The ACOEM states (regarding physical modalities): "There is no high-grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities such as traction, heat/cold applications, massage, diathermy, cutaneous laser treatment, ultrasound, transcutaneous electrical neurostimulation (TENS) units, and biofeedback." Additionally, there are no compelling clinical facts in the medical record indicating additional physical therapy is clinically warranted. Subjectively, according to a March 25, 2015 progress note, the injured worker complains of pain in the low back 7-8/10. Pain radiates down the posterior left leg. The worker states he feels good during the sessions of the pain returns not long after. Objectively, motor examination is grossly normal and there were no significant neurologic abnormalities. Consequently, absent compelling clinical documentation with objective functional improvement and compelling clinical facts indicating additional physical therapy is warranted, physical therapy two times per week times four weeks for the lumbar spine is not medically necessary.