

<b>Case Number:</b>	CM15-0097397		
<b>Date Assigned:</b>	05/28/2015	<b>Date of Injury:</b>	08/26/2007
<b>Decision Date:</b>	06/26/2015	<b>UR Denial Date:</b>	05/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/20/2015

### 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: Massachusetts

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 63-year-old female who sustained an industrial injury on 08/26/2007. Current diagnoses include compression fracture, status post kyphoplasty with residual back pain, lumbar facet osteoarthritis, and lumbar degenerative disc disease. Previous treatments included medication management, kyphoplasty on 02/01/2008, heat/ice, TENS unit, physical therapy, acupuncture, massage therapy, functional restoration program, and activity modification. Report dated 04/29/2015 noted that the injured worker presented with complaints that included back pain and bilateral leg pain. Pain level was 7-8 out of 10 on a visual analog scale (VAS) with medications. Physical examination was positive for lumbar spine tenderness and tightness across the lumbosacral area, restricted range of motion, and sensory exam reveals some hypoesthesia of bilateral toes. The treatment plan included continue with conservative treatments, request for continued coverage of chronic pain medication maintenance regimen, follow up in one month, and request for bilateral medial branch facet injections. Report dated 03/30/2015 notes that the request for physical therapy is to hopefully improve her back pain. Disputed treatments include physical therapy 2 times a week for 4 weeks for the lumbar.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy, 2 times wkly for 4 wks, Lumbar: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (1) Chronic pain, Physical medicine treatment. (2) Preface, Physical Therapy Guidelines.

**Decision rationale:** The claimant has a remote history of a work-related injury and continues to be treated for chronic low back and bilateral lower extremity pain. When seen, pain was rated at 8/10. There was lumbosacral tenderness and decreased range of motion with extension limited completed due to pain. There was decreased lower extremity sensation. The claimant is being treated for chronic pain. There is no new injury. In terms of physical therapy treatment for chronic pain, guidelines recommend a six visit clinical trial with a formal reassessment prior to continuing therapy. In this case, the number of visits requested is in excess of that recommended. The request is not medically necessary.