

<b>Case Number:</b>	CM13-0020068		
<b>Date Assigned:</b>	10/11/2013	<b>Date of Injury:</b>	10/16/2008
<b>Decision Date:</b>	01/15/2014	<b>UR Denial Date:</b>	08/21/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/04/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Sport Medicine and is licensed to practice in New York and Texas. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 61-year-old female who reported an injury on 10/16/2008. The patient reported consistent low back pain that was exacerbated by prolonged driving. The patient's pain failed to respond to medications and epidural steroid injections. The most recent clinical documentation submitted for review does indicate that the patient has restricted range of motion described as 60 degrees in flexion and 5 degrees in extension, with right lateral bending limited by pain at 15 degrees and left lateral bending to 20 degrees. The patient's diagnoses included chronic central low back pain with numbness on the right foot. The patient's treatment plan included continued medication usage and physical therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy 2 times per week for 2 weeks for the 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 rationale:** The requested physical therapy 2 times per week for 2 weeks to the lumbar spine is not medically necessary or appropriate. The patient does have continued back complaints. It is noted within the documentation that the patient does participate in a home exercise program. California Medical Treatment Utilization Schedule states that active therapy is based on the philosophy that therapeutic exercises and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. The clinical documentation submitted for review does indicate that the patient has previously participated in physical therapy with good results. As the patient's pain has not been completely resolved and the patient has not received any physical therapy in over a year, a short course of physical therapy to re-educate the patient and assess the patient's home exercise program would be appropriate. The clinical documentation submitted for review does indicate that the initial request was for 8 physical therapy sessions. The patient received approval for 4 physical therapy sessions. The efficacy of those physical therapy visits was not provided to support the need for additional physical therapy. As such, the requested physical therapy to the lumbar spine is not medically necessary or appropriate.