

<b>Case Number:</b>	CM13-0033081		
<b>Date Assigned:</b>	12/06/2013	<b>Date of Injury:</b>	01/25/2013
<b>Decision Date:</b>	02/18/2014	<b>UR Denial Date:</b>	09/16/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/09/2013

### 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 and Rehabilitation, has a subspecialty in Pain Management and is licensed to practice in California. 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 employee is a 30-year-old female with a date of injury of 1/25/13. A note dated 9/16/13 states, "MD note from 4/13 stated claimant has had 7/12 physical therapy visits, and claimant reports no significant improvement." A progress report dated 5/7/13 states the employee was shown exercises and overall therapy did not seem to help her much. A progress report dated 11/4/13 noted axial pain had improved with a home exercise program. A progress report dated 12/13/13 noted continued gradual improvement of lower back pain radiating to the left leg. Objective findings included the following: moderate tenderness along the left lower paraspinal muscles; painful flexion 45° and painful extension 0°. Neurological symptoms included weakness of left knee extension and dorsiflexion of left foot. It was noted the employee has difficulty heel/toe walking on the left side. Diagnoses include sprain/strain of lumbar region and lumbar radiculopathy. The treatment plan included epidural steroid injection, meloxicam, and trazodone. A progress report dated 12/5/13 indicated the employee had completed 4/6 acupuncture sessions and noted no improvement.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy for the lumbar spine:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298, Chronic Pain Treatment Guidelines Page(s): 98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Physical Therapy.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. The Official Disability Guidelines (ODG) include 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. Based upon the submitted documentation, there is no indication of any objective functional improvement from the therapy already provided. Further, there is no documentation of specific ongoing objective treatment goals and no statement indicating why an independent program of home exercise would be insufficient to address any remaining objective functional deficits. Therefore, the requested physical therapy for the lumbar spine is not medically necessary and appropriate.