

<b>Case Number:</b>	CM13-0043561		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	05/27/2009
<b>Decision Date:</b>	04/18/2014	<b>UR Denial Date:</b>	10/15/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/24/2013

### 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. The expert reviewer is Board Certified in Orthopedic Surgery, 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 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/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 50-year-old with an industrial injury of 5/27/09. The patient is post lumbar fusion. Exam notes from 8/20/13 demonstrate the patient has responded well to acupuncture treatments; his range of motion has increased with less sensation of pain. Exam notes from 8/21/13 demonstrate patient continues to have right-sided back pain and leg pain. Patient walks with severe antalgic like gait with right-sided limp. X-rays show stable instrumentation on the left side of L4-S1. Claimant having difficulty sitting for long periods of time. Request is for physical therapy 2 times a week for 4 weeks for evaluation and treatment of the 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 TIMES PER WEEK FOR 4 WEEKS FOR EVALUATION AND TREATMENT OF THE LUMBAR;; Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99. Decision based on Non-MTUS Citation Pain, Suffering, and the Restoration of Function Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 6), page 114.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 48-49.

**Decision rationale:** The claimant did sustain acute flare of low back pain in the records and meets criteria for initial course of physical therapy. If functional improvement is demonstrated then further visits would be reasonably necessary. A request for eight visits exceeds an initial course of therapy. The request for physical therapy for evaluation and treatment of the lumbar, twice per week for four weeks, is not medically necessary or appropriate.

**CLOSED 1.5 TESLA UNIT (MRI OF THE LUMBAR SPINE):** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

**Decision rationale:** In this particular patient there is no indication of criteria for an MRI based upon physician documentation or physical examination findings. There is no documentation nerve root dysfunction or failure of a conservative treatment program. The request for a closed 1.5 Tesla unit (MRI of the lumbar spine) is not medically necessary or appropriate.