

<b>Case Number:</b>	CM13-0050633		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	03/18/2013
<b>Decision Date:</b>	04/29/2014	<b>UR Denial Date:</b>	01/09/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/14/2013

### 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 Occupational Medicine, 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 42-year-old who was injured on March 18, 2013. The patient slipped and fell on stairs and hurt the lumbar spine and right knee. Prior treatment history has included 24 sessions of physical therapy, 14 post-op sessions. The patient underwent posterior L3 through L5 spinal fusion on 05/31/2013. Diagnostic studies reviewed include MRI of the right knee performed on 07/22/2013 revealed patellofemoral chondromalacia. CT of the lumbosacral spine without contrast performed on 05/06/2013 revealed lumbar levoscoliosis (There is grade 1 right lateral listhesis of L4 on L5. There is also grade 1 retrolisthesis of L4 on L5), L5-6 degenerative disc disease (there has been previous left laminectomy and facetectomy at this level; There is residual disc bulging with no more than mild spinal and foraminal stenosis), grade 1 retrolisthesis of L4 on L5 and disc bulging (there appears to be no more than mild spinal and foraminal stenosis), and right L5-6 facet degenerative disease. An X-ray of the lumbar performed on May 31, 2013 revealed instrument localization of penultimate lowest lumbar disc level, most often L4-5. MRI of the L-spine performed on May 31, 2013, revealed posterior lumbar fusion L3 to L5 as described; bony alignment anatomic. MRI of L-spine with and without contrast performed on 04/22/2013 revealed: 1. Status post left L4-L5 hemilaminectomy with interval resolution of previously demonstrated recurrent disc herniation at this level. However, there is progressive scar tissue at the laminectomy site extending into the left axillary recess and encircling the left L5 nerve root sleeve with progressive mild left foraminal stenosis as well. 2. Progressive eccentric right subarticular disc bulge at L3-L4 resulting in increased moderate right lateral recess stenosis 3. Progressive right sided Modic type I degenerative end plate changes at L4-L5 4. Normal conus medullaris with no evidence of cord compression; no lumbar compression fracture 5. Otherwise no significant change compared to MRI of the lumbar spine dated 12/06/2012. Spine Re-Evaluation dated October 10, 2013, documented the patient to report that

her low back is slightly better with decreased symptoms to right lower extremity and being able to perform functional mobility and transfers with decreased soreness to low back. However, the patient continues to have decreased tolerated with seated activities. The patient states being able to tolerate about 1.5 hours of sitting prior to moderate to severe low back pain. Objective findings on exam revealed the patient is able to perform bed mobility and functional transfers with proper body mechanics with mild discomfort; moderate tenderness to right greater than left; glut/piriformis and right greater than left, L2-5 paraspinals with palpation. She has an antalgic gait. It was recommended that the patient would benefit from further physical therapy to improve tolerance to work relate tasks with decreased pain. The treatment plan consists of range of motion, strengthening, gait training, posture training, HEP (home exercise program), and manual therapy with a frequency of 2 visits each for 6 weeks. Physical Therapy Visit dated October 21, 2013, indicated the patient reported increased low back pain with week without physical therapy. The patient states increased tightness to B glut/piriformis with functional WB activities. Objective findings on exam revealed moderate to severe tenderness to right greater than left glut/piriformis soreness/tightness with mobility and ambulation. The patient was recommended to continue with current treatment plan.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**12 SESSIONS WITH A PERSONAL TRAINER:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**Decision rationale:** This is a request for twelve sessions with a personal trainer apparently for right knee pain and chronic low back pain with history of three lower back surgeries. The latest back surgery was L3-5 fusion on May 31, 2013. The patient underwent post-operative physical therapy treatment with improvement. The total number of visits is not clear from the record though the patient is now beyond the recommended treatment period of 6 months. It is not clear from the record why a personal trainer is being requested. A personal trainer is not a medical professional, and thus is probably not the most appropriate choice for an individual with a history of failed back surgery, chronic low back pain, chronic R knee pain, and functional limitations. It is also not clear why the patient cannot transition to a home exercise program at this point. The request for twelve sessions with a personal trainer are not medically necessary or appropriate.