

<b>Case Number:</b>	CM13-0053235		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	02/10/2011
<b>Decision Date:</b>	12/17/2014	<b>UR Denial Date:</b>	11/14/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/18/2013

### 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 Family 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:

This is a 33-year-old male patient who reported an industrial injury to the back on 2/10/2011, almost four (4) years ago, attributed to the performance of his usual and customary job duties. The patient is being treated for the diagnoses of lumbago; thoracic or lumbosacral neuritis or radiculitis; sciatica; displacement of lumbar intervertebral disc without myelopathy; sacroiliitis; lumbosacral spondylosis without myelopathy; degeneration of lumbar or lumbar sacral intervertebral discs. The patient was previously treated with physical therapy and bilateral SI injections. The objective findings on examination included restricted range of motion of the lumbar spine; tenderness in the midline over the spinous processes; tenderness with facet loading; SLR negative; reflexes were 2+ bilaterally.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Twelve visits of physical therapy:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, [www.odg-twc.com](http://www.odg-twc.com); Section: Low back-Lumbar & Thoracic (Acute & Chronic) (updated 10/092013).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299-300, Chronic Pain Treatment Guidelines Physical Medicine Page(s): 97-98.

Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) neck and upper back chapter-PT; back chapter-PT.

**Decision rationale:** The request is for authorization of 12 additional sessions of PT to the back four (4) years after the DOI exceeds the number of sessions of PT recommended by the CA MTUS and the time period recommended for rehabilitation. The evaluation of the patient documented no objective findings on examination to support the medical necessity of physical therapy over the recommended self-directed home exercise program with documented weakness but no muscle atrophy as opposed to a self-directed HEP. There are no objective findings to support the medical necessity of 12 additional sessions of physical therapy for the rehabilitation of the patient over the number recommended by evidence-based guidelines. The patient is noted to be status post prior sessions of rehabilitation physical therapy. The patient is documented with no signs of significant weakness, no significant reduction of ROM, or muscle atrophy. There is no demonstrated medical necessity for the prescribed PT to the back four (4) years after the DOI. The patient is not documented to be in HEP. There is no objective evidence provided by the provider to support the medical necessity of the requested 12 additional sessions of PT over a self-directed home exercise program. The CA MTUS recommends ten (10) sessions of physical therapy over eight (8) weeks for the lumbar spine rehabilitation subsequent to lumbar/thoracic strain/sprain and lumbar spine DDD with integration into HEP. The provider did not provide any current objective findings to support the medical necessity of additional PT beyond the number recommended by evidence-based guidelines. The request for an additional 12 sessions of physical therapy directed to the back is not demonstrated to be medically necessary over the recommended self-directed home exercise program. The patient has exceeded the CA MTUS recommended time period for rehabilitation of a lower back strain or lumbar radiculopathy. Therefore, the request is not medically necessary.