

<b>Case Number:</b>	CM13-0061515		
<b>Date Assigned:</b>	05/07/2014	<b>Date of Injury:</b>	10/03/2006
<b>Decision Date:</b>	06/12/2014	<b>UR Denial Date:</b>	11/07/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/05/2013

### 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 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 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 injured worker is a 51-year-old male who reported an injury on 10/03/2006, due to a motor vehicle accident. The clinical note dated 03/31/2014 presented the injured worker with neck pain that radiated down the bilateral upper extremities, low back pain radiating down the lower extremity, and pain aggravated by activity and walking. His pain was rated at 7/10 with medications, and 9/10 without medications. The injured worker had a slow gait and was in moderate distress. The injured worker's diagnoses included failed back surgery syndrome, lumbar radiculopathy, status post fusion, lumbar spine, medication related dyspepsia, vitamin D deficient, and status post right shoulder surgery. The provider recommended continued conservative therapy. The request for authorization form was included in this review; however, it was not dated.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CONTINUED CONSERVATIVE THERAPY (ABSENT A GYM MEMBERSHIP RECOMMENDATION FOR AN ADDITIONAL 6 WEEKS OF THERAPY): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
PHYSICAL MEDICINE Page(s): 98.

**Decision rationale:** The Chronic Pain Guidelines indicate that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. There was a lack of documentation indicating the injured workers prior course of physical therapy as well as the efficacy of the prior therapy. The documentation provided is unclear as to how physiotherapy would provide the injured worker with functional restoration. The requesting physician did not include an adequate and complete assessment of the injured workers current objective functional condition. The provider also suggested at-home self-managed therapy for the injured worker. Therefore, the request is non-certified.