

<b>Case Number:</b>	CM13-0072221		
<b>Date Assigned:</b>	01/17/2014	<b>Date of Injury:</b>	01/09/2013
<b>Decision Date:</b>	04/30/2014	<b>UR Denial Date:</b>	12/18/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/30/2013

### 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 Anesthesiology has a subspecialty in Pain Management and is licensed to practice in Texas and Florida. 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 sustained injury on 1/9/2013 after a fall on the ice. On 11/15/13 she complained of low back pain radiating down the right lower extremity. The X-ray of the lumbar spine showed mild degenerative disc disease and spondylosis. The diagnoses listed are SI joint dysfunction, lumbago, low back pain, insomnia and status post right shoulder surgery. The current medications are Advil 200mg, Ultram 50mg and Voltaren gel for pain and Temazepam 15mg for insomnia. ██████████ noted on 11/19/2013 that the patient was still doing physical therapy for post shoulder surgery phase IV rehabilitation. The patient had previously completed Chiropractic treatment by ██████████. A Utilization Review on 12/18/2013 recommended a modified certification of 6 physical therapy treatment not the requested 3 per week for 6 weeks.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy for the Low Back Three (3) times a week for Six (6) weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine. Decision based on Non-MTUS Citation ODG, Physical Medicine Treatment (including PT, OT, and Chiropractic Care)

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

**Decision rationale:** The CA MTUS addressed the use of physical therapy for the treatment of low back pain. A total of 9-10 physical therapy treatment completed in an 8 week period is recommended. The patient would then be reevaluated for functional improvement and the need for additional physical therapy. The most recent available medical records indicate that the patient was still undergoing physical therapy in November 2013. There is no post physical therapy reevaluation report supporting the need for additional physical therapy more than the 6 Physical Therapy sessions already approved for the back. The request exceeds the MTUS Guidelines and as such is not certified.