

<b>Case Number:</b>	CM14-0003682		
<b>Date Assigned:</b>	01/31/2014	<b>Date of Injury:</b>	04/03/2013
<b>Decision Date:</b>	06/20/2014	<b>UR Denial Date:</b>	12/10/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/09/2014

### 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 Physical Medicine and Rehabilitation, 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 44-year-old male who reported an injury on April 3, 2013. The mechanism of injury was the injured worker was unloading metal bearing concrete fire doors weighing over 100 pounds when he had the onset of low back pain with radiation down the right lateral thigh and calf to the dorsum of the right foot and great toe with pain and numbness and paresthesias in the same distribution. The documentation of November 19, 2013 revealed that the injured worker had complaints of constant moderate back pain rated at 7/10 to 10/10. Physical examination revealed the injured worker's gait was mildly antalgic due to low back pain. The range of motion was decreased. The injured worker had a positive Faber's test on the left. The sensation was intact bilaterally to the lower extremities and the strength was 5/5. The injured worker had hypesthesia in the right anterolateral lower leg. The injured worker had a nerve conduction study on May 30, 2013 and electromyography which revealed a normal nerve conduction study and an abnormal electromyography suggestive of bilateral chronic active L4-5 radiculopathy right greater than left side. Diagnoses include HNP L4-5 with right lower extremity L5 lumbar radiculopathy. The treatment plan included medications and physical therapy 2 times a week for 4 weeks.

### 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 THE LUMBAR SPINE:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, PHYSICAL MEDICINE, 7, 98-99

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98,99.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines recommends physical medicine treatment with a maximum of eight to ten visits for the treatment of neuralgia, neuritis, and radiculitis. There should be a transition into a home program. The clinical documentation submitted for review indicated the injured worker reported the injury on April 3, 2013. There was a lack of documentation indicating prior therapies that were attended. There was a lack of documentation indicating objective functional deficits to support the necessity for ongoing therapy. The request for physical therapy for the lumbar spine twice weekly for four weeks, is not medically necessary or appropriate.