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| <b>Case Number:</b>   | CM14-0008309 |                              |            |
| <b>Date Assigned:</b> | 02/07/2014   | <b>Date of Injury:</b>       | 01/18/2011 |
| <b>Decision Date:</b> | 06/30/2014   | <b>UR Denial Date:</b>       | 01/07/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 01/22/2014 |

### 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 has a subspecialty in Pain Medicine and is licensed to practice in Minnesota. 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 40-year-old female who reported an injury on 01/18/2011. The mechanism of injury was not provided in the documentation. Per the clinical note dated 07/09/2013 the injured worker reported low back pain with pain radiation down posterior thighs to the knee with muscle spasms. The injured worker stated she was not utilizing any medications due to breastfeeding. On physical exam the straight leg raise was moderately positive. Motor and sensory exams were normal, reflexes were 1-2+ bilaterally and no pathological reflexes were evident. Per the progress note dated 11/21/2013, the injured worker reported increased neck pain with headaches. The injured worker's diagnoses included neck sprain/strain, degenerative disc, impingement syndrome, and sprain/strain of the shoulder. The Request for Authorization of medical treatment and the provider's rationale for 8 visits of physical therapy for the lumbar spine were not provided in the documentation. The injured worker underwent an injection of Toradol and was on a 25 pound lifting restriction.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PHYSICAL THERAPY, 8 VISITS, LUMBAR SPINE:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM 2004 OMPG, 12, LOW BACK, 288

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

**Decision rationale:** According to CA MTUS Guidelines, 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. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. The guidelines recommend 8-10 visits over 4 weeks. In addition, allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. There was a lack of documentation, both subjective and objective, to indicate the need for physical therapy. There was a lack of documentation regarding other conservative treatments for the injured worker or prior physical therapy for the lumbar spine. The injured worker's motor strength was normal and intact. There was a lack of recent clinical data regarding the lumbar spine including an adequate assessment of the injured worker's condition which demonstrated significant functional deficits. The provider's rationale for the requested physical therapy was not provided within the documentation. In addition, the frequency of the requested treatment was not provided. Therefore, the request for physical therapy, 8 visits, lumbar spine is non-certified.