

<b>Case Number:</b>	CM14-0108185		
<b>Date Assigned:</b>	08/01/2014	<b>Date of Injury:</b>	01/25/2012
<b>Decision Date:</b>	09/17/2014	<b>UR Denial Date:</b>	06/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/11/2014

### 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 Orthopedic Spine 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 52 -year-old female who reported injury on 01/25/2012. The mechanism of injury was the injured worker was reaching for a tub of butter weighing approximately 10 pounds and one of the tubs was not properly placed and 2 of the plastic tubs fell, striking the injured worker on the anterior aspect of her right shoulder, causing her to lose balance and fall backwards striking the back of her neck and low back against shelves that were behind her. The injured worker underwent an anterior lumbar interbody fusion at L4-5 and L5-S1 on 01/14/2014. The injured worker underwent an anterior cervical fusion in 02/2013. Other therapies included 12 sessions of postoperative physical therapy and medications. The medications were noted to include Vicodin, Naprosyn and Prilosec. The diagnostic studies included an MRI of the lumbar spine. The physical examination of 06/19/2014, revealed the injured worker had tenderness over the right sacroiliac joint and the right greater trochanteric bursa. The injured worker had decreased range of motion of the lumbar spine. The straight leg raise was negative in the sitting and supine positions. There was no Request for Authorization or physician note submitted for the request.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy 2xwk X 6wks, Lower Back: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines  
Page(s): 26.

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

**Decision rationale:** The California MTUS Guidelines recommend 9 to 10 visits of physical medicine treatment for myalgia and myositis. The clinical documentation submitted for review indicated the injured worker had previously attended 12 sessions of therapy. There was a lack of documented rationale for the request. There was a lack of documentation of objective functional benefit that was received and objective functional deficits that remained. Given the above, the request for physical therapy 2 times a week times 6 weeks lower back is not medically necessary.