

<b>Case Number:</b>	CM14-0113354		
<b>Date Assigned:</b>	08/01/2014	<b>Date of Injury:</b>	11/16/2011
<b>Decision Date:</b>	09/10/2014	<b>UR Denial Date:</b>	07/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/21/2014

### 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 Illinois. 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 58-year-old female who reported an injury on 11/16/2011. Reportedly while working for [REDACTED] as a store manager, she injured her back. She was pushing and pulling a cart full of cases of hamburger from the back room to the front of the store and noticed radiation of pain from her left hip to her left leg and left foot. The injured worker's treatment history included MRI, EMG/NCV, medications, x-rays, surgery, and physical therapy. The injured worker was evaluated on 06/24/2014, and it was documented that information was not taken this visit, and information not collected. Medications included Robaxin, hydromorphone, amitriptyline, Skelaxin, and trazodone. The injured worker had undergone a left greater trochanteric bursa injection. The injured worker tolerated the procedure well. There were no complications. Diagnoses included degeneration of lumbar or lumbosacral intervertebral disc, myalgia and myositis, and pain in joint, hip (pelvic region and thigh). The Request for Authorization and rationale were not submitted for this review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy 2xWk x 4Wks Low Back:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical medical Guidelines Page(s): 98-99.

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

**Decision rationale:** The request is non-certified. The California MTUS Guidelines may support up to 10 visits of physical therapy for the treatment of unspecified myalgia and myositis to promote functional improvement. The documents submitted lacked outcome measurements of prior physical therapy sessions and home exercise regimen. In addition, long term functional goals were not provided for the injured worker. Given the above, the request for physical therapy 2X WK for 4WKS for low back is non-certified.