

<b>Case Number:</b>	CM14-0167583		
<b>Date Assigned:</b>	10/14/2014	<b>Date of Injury:</b>	06/13/2011
<b>Decision Date:</b>	11/19/2014	<b>UR Denial Date:</b>	09/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/10/2014

### 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 Occupational Medicine and is licensed to practice in California. 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:

Injured worker is a male with date of injury 6/13/2011. Per primary treating physician's progress report dated 7/17/2014, the injured worker complains of constant pain in the low back that is aggravated by bending, lifting, twisting, pushing, pulling, prolonged sitting, prolonged standing, walking multiple blocks. The pain is characterized as sharp. There is radiation of pain into the lower extremities. His pain is unchanged, and is rated 7/10. On examination there is palpable paravertebral muscle tenderness with spasm. Seated nerve root test is positive. Standing flexion and extension are guarded and restricted. There is tingling and numbness in the lateral thigh, anterolateral and posterior leg as well as foot. There is 4 strength in the EHL and ankle flexors, L45 and S1 innervated muscles. Ankle reflexes are asymmetric. Diagnosis is lumbago.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**[Additional] PT Lumbar Spine x 12: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine.

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

**Decision rationale:** The MTUS Guidelines recommend physical therapy focused on active therapy to restore flexibility, strength, endurance, function, range of motion and alleviate discomfort. The MTUS Guidelines support physical therapy that is providing a documented benefit. Physical therapy should be provided at a decreasing frequency (from up to 3 visits per week to 1 or less) as the guided therapy becomes replaced by a self-directed home exercise program. The physical medicine guidelines recommend myalgia and myositis, unspecified; receive 9-10 visits over 8 weeks. The medical records do not clearly indicate functional improvement with prior physical therapy as indicated by improvement of activities, return to work, or examination findings. The number of sessions completed to date is also not reported. The implementation of a home exercise program is not reported. The number of sessions requested is also in excess of the number recommended by the MTUS Guidelines. The request for [Additional] PT Lumbar Spine x 12 is determined to not be medically necessary.