

<b>Case Number:</b>	CM14-0185735		
<b>Date Assigned:</b>	11/13/2014	<b>Date of Injury:</b>	01/17/1996
<b>Decision Date:</b>	12/30/2014	<b>UR Denial Date:</b>	10/22/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/07/2014

### 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 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:

The underlying date of injury in this case is 01/17/1996. The date of the utilization review under appeal is 10/22/2014. The patient's diagnoses include lumbago, right sacroiliitis, coccydynia, and right leg radiculopathy. On 10/09/2014, the patient was seen in primary treating physician follow-up. The patient had the chief complaint of lower right back pain and right sacroiliac pain as well as right leg pain to the great toe, coccyx pain, and right leg numbness. The patient reported ongoing chronic low back pain as well as right sacroiliac pain and coccyx pain. The patient had received physical therapy previously, although her symptoms were only temporarily improved. A request was made for 12 additional sessions of physical therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**12 Physical therapy for the lumbar spine 3 times a week for 4 weeks, outpatient:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

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

**Decision rationale:** The Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines, section on physical medicine, recommend transition to an active

independent home rehabilitation program. In this chronic setting, if additional supervised physical therapy were desired, it would be appropriate for the treating physician to specify a specific rationale and goals of this therapy with the anticipation of an outcome different from prior apparently ineffective or limited outcome. There is very limited specificity as to the specific rationale or goals of additional physical therapy at this time. This request is not supported by the treatment guidelines. Overall this request is not medically necessary.