

<b>Case Number:</b>	CM14-0021339		
<b>Date Assigned:</b>	06/13/2014	<b>Date of Injury:</b>	07/15/2013
<b>Decision Date:</b>	07/15/2014	<b>UR Denial Date:</b>	02/05/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/20/2014

### 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 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 49 year old male whose date of injury is 07/15/2013. The mechanism of injury is described as a backwards fall from approximately 12 feet. Treatment to date includes bracing, medication management, aquatic and physical therapy. Office visit note dated 01/27/14 indicates that he complains of mid lower lumbar region pain. Since last visit activity level has remained the same. Pain level has remained the same. The injured worker has never had spine surgery. On physical examination lumbar range of motion is full. Straight leg raising is negative bilaterally. Impression notes other unspecified lumbar disorder, compression fracture nos, and dislocated lumbar vertebra. According to the record the injured worker is not getting better and cannot go back to work.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PHYSICAL THERAPY 2 TIMES A WEEK FOR 6 WEEKS FOR THE LUMBAR SPINE:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy and manipulation Page(s): 58-60.

**Decision rationale:** Based on the clinical information provided, the request for physical therapy 2 times a week for 6 weeks for the lumbar spine is not recommended as medically necessary. The injured worker has completed a course of physical therapy without significant benefit documented. Serial records indicate that pain level and activity level have remained the same. The injured worker has not been able to return to work. California Medical Treatment Utilization Schedule Guidelines would support 1-2 visits every 4-6 months for recurrence/flare-up and note that elective/maintenance care is not medically necessary. There are no specific, time-limited treatment goals provided.