

<b>Case Number:</b>	CM14-0036895		
<b>Date Assigned:</b>	06/25/2014	<b>Date of Injury:</b>	08/23/2012
<b>Decision Date:</b>	08/14/2014	<b>UR Denial Date:</b>	03/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/26/2014

### 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 Anesthesiology, has a subspecialty in Pain 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 47 year old female whose date of injury is 01/31/2012. The mechanism of injury is described as bending over to tie shoe laces and felt pain in the lower back. Progress note dated 06/02/14 indicates that the injured worker complains of continued low back pain with pain into her left greater than right leg. Pain increased with physical therapy. On physical examination there is normal gait and arm swing with no assistive device. There is 5/5 strength in the lower extremities and the injured worker is neurologically intact. Diagnosis is lumbar spine sprain/strain and lumbar spondylosis. The note states that the injured worker is not benefitting from therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Outpatient Physical Therapy for the low back, 3 times a week for 4 weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter, Traction.

**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 outpatient physical therapy for the low back 3 times a week for 4 weeks is not recommended as medically necessary. The submitted records indicate that the injured worker's pain is increased with physical therapy and the injured worker is not benefitting from physical therapy. Therefore, efficacy of treatment is not established, and it is unclear why the injured worker is being recommended for additional treatment that has not been beneficial to date. CA MTUS Guidelines would support 1-2 visits every 4-6 months for recurrence/flare-up and note that elective/maintenance care is not medically necessary. The injured worker has completed sufficient formal therapy and should be capable of continuing to improve strength and range of motion with an independent, self-directed home exercise program. Therefore, the request is not medically necessary.