

<b>Case Number:</b>	CM14-0051875		
<b>Date Assigned:</b>	07/07/2014	<b>Date of Injury:</b>	09/12/2001
<b>Decision Date:</b>	08/29/2014	<b>UR Denial Date:</b>	03/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/21/2014

### 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, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 61-year-old female who reported an injury on 09/12/2001. Mechanism of injury is unknown. The injured worker's diagnoses were cervical spondylosis C3-7 and degenerative disc disease with central disc protrusion and annular tears at L4-5 and L5-S1, moderate central stenosis of the L4-5. The injured worker complains of back pain which exceeds his neck pain that radiates into the right buttock, posterior and lateral thigh and calf, to the foot associated with intermittent numbness and tingling. The injured worker's prior treatments were medication management. On physical examination dated 03/10/2014, the injured worker appeared to be uncomfortable. Lumbar range of motion is moderately restricted in all planes with pain at the limits of his range. The injured worker's medications were Vicodin, Xanax, and ibuprofen. Treatment plan is to proceed with surgical procedure that the injured worker would pursue if authorized. The rationale for the request was not submitted with documentation. The Request for Authorization form was not provided with documentation submitted for review.

### 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:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** The request for physical therapy 2 times a week for 6 weeks for the lumbar spine is non-certified. The California MTUS Guidelines may support for neuralgia, neuritis and radiculitis, unspecified, 8 to 10 visits over 4 weeks. The injured worker is noted to have moderately restricted range of motion in all planes due to pain. There is lack of documentation of previous physical therapy sessions directed towards the lumbar spine. The request for physical therapy 2 times a week for 6 weeks for the lumbar spine is not supported by guidelines that allows 9 to 10 visits over 8 weeks, the request would exceed guidelines. As such, the request is non-certified.