

<b>Case Number:</b>	CM14-0055475		
<b>Date Assigned:</b>	07/09/2014	<b>Date of Injury:</b>	10/08/2007
<b>Decision Date:</b>	09/03/2014	<b>UR Denial Date:</b>	04/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/24/2014

### 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 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 injured worker is a 60 year old female whose date of injury is 10/08/07. The mechanism of injury is described as lifting. Treatment to date includes physical therapy x 24, facet injection on 10/02/12, epidural steroid injections, radiofrequency ablation on 08/06/13 and massage therapy. Diagnoses are lumbar facet arthropathy, status post radiofrequency ablation, acquired spondylolisthesis, chronic low back pain. Visit note dated 06/06/14 indicates that the injured worker is not working at this time. On physical examination there is tenderness to palpation at the lumbosacral junction. Motor strength is 5/5 in the lower extremities. Sensation is intact. Deep tendon reflexes are 1+ and equal.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Additional Physical Therapy x 6 (lower back): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines Physical Therapy Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines, Lumbar Chapter.

**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 additional physical therapy x 6 (lower back) is not recommended as medically necessary. The submitted records indicate that the injured worker has undergone extensive prior physical therapy. The injured worker reports that she is not compliant with her home exercise program and performs it intermittently, but notes that she does still have the equipment. There are no specific, time-limited treatment goals provided. 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.