

<b>Case Number:</b>	CM14-0055680		
<b>Date Assigned:</b>	07/09/2014	<b>Date of Injury:</b>	03/13/2013
<b>Decision Date:</b>	09/19/2014	<b>UR Denial Date:</b>	03/24/2014
<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 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 patient is a 48 year old male who was injured on 03/13/2013. The mechanism of injury is unknown. Prior treatment history has included 30 sessions of physical therapy without documented improvement; epidural steroid injection with some relief and TENS. Prior medication history included Naproxen, Protonix, Flexeril, and Norco. Diagnostic studies reviewed include MRI of the lumbar spine revealed L4-L5 level shows decreased disc height with moderate spinal stenosis and left-sided severe foraminal stenosis. Ortho report dated 01/20/2014 states the patient complained of nagging pain in the lower back. On exam, the lumbar exam revealed tenderness and spasm in the paravertebral muscle. Lumbar range of motion revealed forward flexion is 60 degrees finger to ankle; extension 25 degrees; lateral flexion on the right is 25 degrees; lateral flexion on the left is 25 degrees. Straight leg raise is 90 degrees bilaterally. He is diagnosed with lumbosacral radiculopathy and degenerative disk disease. The patient is recommended for physical therapy to the lumbar spine. Prior utilization review dated 03/24/2014 states the request for Physical Therapy Once (1) a week for Four (4) weeks, Lumbar Spine is not certified as it is not medically necessary.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy Once (1) a week for Four (4) weeks, Lumbar Spine.: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic, Physical therapy.

**Decision rationale:** The CA MTUS and ODG Guidelines recommend physical therapy for short term treatment of musculoskeletal conditions in order to reduce local tissue inflammation and reduce acute pain symptoms. Active physical therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. The medical records submitted document the patient to have received 30 sessions of PT for this condition with no documented improvement in symptoms or function. Further, the documents show no transition or use of a home based exercise program which is recommended by the treatment guidelines. Based on the CA MTUS and ODG guidelines and criteria as well as the clinical documentation stated above, the request is not medically necessary. The request is non-certified.