

<b>Case Number:</b>	CM14-0079997		
<b>Date Assigned:</b>	07/18/2014	<b>Date of Injury:</b>	06/21/2003
<b>Decision Date:</b>	08/15/2014	<b>UR Denial Date:</b>	05/09/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/30/2014

### 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 & Rehabilitation has a subspecialty in Pain Management 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:

This is a male patient with the date of injury of June 21, 2003. A Utilization Review was performed on May 12, 2014 and recommended non-certification of physical therapy 2x/week for 4 weeks (lumbar spine). A Visit Note dated May 7, 2014 identifies Subjective Complaints of back pain radiating from low back down both legs. Objective Findings identify range of motion is restricted. Paravertebral muscles tenderness and tight muscle band is noted on both the sides. Patient can't walk on heel, can't walk on toes. Tenderness noted over along spinal column. Light touch sensation is patchy in distribution. Diagnoses identify post lumbar laminectomy syndrome, disc disorder lumbar, sacroiliac pain, lumbar/lumbosacral disc degeneration, lumbar disc displacement, broken screw in fusion surgery, and SCS in place. Treatment Plan identifies patient has completed PT, has been encouraged to continue HEP.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy two (2) tikes a week for four (4) weeks lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines Page(s): 98-99.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298, Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective

July 18, 2009) Page(s): 98. Decision based on Non-MTUS Citation Non-MTUS Official Disability Guidelines (ODG), Low Back Chapter, Physical Therapy.

**Decision rationale:** Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. ODG supports up to 12 visits. Within the documentation available for review, the number of previous visits completed is unknown. There is no indication of any objective functional improvement from the therapy already provided, no documentation of specific ongoing objective treatment goals, and no statement indicating why an independent program of home exercise would be insufficient to address any remaining objective deficits. In the absence of such documentation, the current request for physical therapy 2 times a week for 4 weeks lumbar spine is not medically necessary.