

<b>Case Number:</b>	CM14-0087257		
<b>Date Assigned:</b>	07/23/2014	<b>Date of Injury:</b>	12/11/2013
<b>Decision Date:</b>	12/31/2014	<b>UR Denial Date:</b>	05/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/10/2014

### 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 Emergency 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 24 year-old male, who sustained an injury on December 11, 2013. The mechanism of injury occurred when a wall collapsed on him. Diagnostics have included: January 11, 2014 lumbar MRI reported as showing no abnormalities. Treatments have included: physical therapy, medications. The current diagnoses are: lumbar strain, cervical strain, thoracic strain. The stated purpose of the request for physical therapy 3 times a week for 6 weeks, lower back was not noted. The request for physical therapy 3 times a week for 6 weeks, lower back was denied on May 26, 2014, citing a lack of documentation of functional improvement. Per the report dated March 24, 2014, the treating physician noted complaints of low back pain with radiation to both lower extremities. Exam findings included restricted lumbar range of motion with negative straight leg raising tests and normal motor and sensory functions.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy 3 times a week for 6 weeks, Lower Back: Upheld**

**Claims Administrator 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, Physical Therapy

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) , ODG Physical Therapy Guidelines, Low Back Complaints, Physical Therapy

**Decision rationale:** The requested physical therapy 3 times a week for 6 weeks, lower back, is not medically necessary. CA MTUS, ACOEM 2nd Edition, 2004, Chapter 12, Low Back Complaints, page 300 and ODG Treatment in Workers Compensation, ODG Physical Therapy Guidelines, Low Back Complaints, Physical Therapy, recommend up to 10 physical therapy sessions for this condition, and continued physical therapy with documented derived functional benefit. The injured worker has low back pain with radiation to both lower extremities. The treating physician has documented restricted lumbar range of motion with negative straight leg raising tests and normal motor and sensory functions. Even though additional physical therapy may be warranted, the treating physician has not documented the medical necessity for additional physical therapy in excess of the guideline-supported recommendation of 10 physical therapy sessions. The criteria noted above have not been met. Therefore, this request for physical therapy 3 times a week for 6 weeks, lower back is not medically necessary.