

<b>Case Number:</b>	CM14-0014610		
<b>Date Assigned:</b>	02/28/2014	<b>Date of Injury:</b>	11/28/2012
<b>Decision Date:</b>	04/01/2015	<b>UR Denial Date:</b>	01/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/05/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Texas, Florida

Certification(s)/Specialty: Anesthesiology, Pain Management

### 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 47 year old female, who sustained an industrial injury reported on 11/28/2012. She has reported low back pain radiating to the lower extremities right greater than left and thoracic spine pain. The pain score was reported as 5-7/10 on a scale of 0 to 10. There were objective findings of decreased range of motion of lumbar spine and tenderness to palpation. The diagnoses were noted to have included lumbosacral spondylolisthesis with myofascial pain. Treatments to date have included consultations, diagnostic urine studies, physical therapy and home exercise program, activity modifications, heat/cold therapy and medication management that. The work status classification for this injured worker (IW) was noted. The medications listed are Naprosyn and pantoprazole. On 1/30/2014, Utilization Review (UR) non-certified, for medical necessity, the request, made on 1/21/2014, for 12 outpatient physical therapy treatments, 3 x a week x 4 weeks, for spondylolisthesis. The Medical Treatment Utilization Schedule, chronic pain physical medicine guidelines, physical therapy, passive therapy, was cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**OUTPATIENT PHYSICAL THERAPY VISITS THREE TIME PER WEEK FOR FOUR WEEKS FOR THE LUMBAR SPINE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Page(s): 22,46-47, 96-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)Pain ChapterLow and Upper Back.

**Decision rationale:** The CA MTUS and the ODG guidelines recommend that physical therapy (PT) can be utilized for the treatment of musculoskeletal pain. The utilization of PT can result in functional restoration, decreased medications use and reduction in pain. The guidelines recommend that patients proceed to a home exercise program after completion of supervised PT. The records indicate that the patient completed supervised PT before progressing to a home exercise program. There is no documentation of recent exacerbation of pain that requiring commencement of another round of supervised PT program. The criteria for 12 outpatient physical therapy sessions at 3 times a week for 4 weeks to lumbar spine was not met.