

<b>Case Number:</b>	CM15-0103641		
<b>Date Assigned:</b>	06/08/2015	<b>Date of Injury:</b>	02/24/2015
<b>Decision Date:</b>	07/07/2015	<b>UR Denial Date:</b>	05/19/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/29/2015

### 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: California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

### 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 44 year old male, who sustained an industrial injury on February 24, 2015. The injury occurred while the injured worker was lifting a heavy sandbox. The injured worker sustained a low back injury. The diagnoses have included chronic lumbar sprain/strain, lumbar bilateral radiculopathy and chronic pain syndrome. Treatment to date has included medications, radiological studies, MRI, injections, heat treatments and a lumbar support. Current documentation dated March 13, 2015 notes that the injured worker reported worsening low back pain with radiation to the left lower extremity. Associated symptoms included numbness and difficulty walking. Examination of the lumbar spine revealed significant tenderness to palpation of the lower back and a restricted range of motion. A straight leg raise was positive on the left. MRI was normal. The treating physician's plan of care included a request for physical therapy 6 sessions to the lumbar spine. There is no documentation supporting prior physical therapy sessions.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy lumbar:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299. Decision based on Non-MTUS Citation Official Disability Guidelines Low Back - Physical Therapy.

**Decision rationale:** MTUS Guidelines support the use of physical therapy for low back pain. ODG Guideline provides additional details regarding what would be a reasonable number of sessions, which the Guidelines consider up to 9 sessions as reasonable. The request is for 6 sessions of physical therapy and there is no evidence in the records that any physical therapy sessions have been provided. Under these circumstances, the physical therapy lumbar is supported by Guidelines and is medically necessary.