

<b>Case Number:</b>	CM15-0046313		
<b>Date Assigned:</b>	03/18/2015	<b>Date of Injury:</b>	03/05/2013
<b>Decision Date:</b>	04/23/2015	<b>UR Denial Date:</b>	02/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/11/2015

### 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: Maryland

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Neuromuscular 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 61-year-old male who sustained an industrial injury on 3/5/13. The injured worker reported symptoms in the back. The injured worker was diagnosed as having spondylolisthesis lumbosacral region, lumbar myofascial sprain/strain, sacroiliac ligament sprain/strain and spinal stenosis lumbar. Treatments to date have included non-steroidal anti-inflammatory drugs, activity modification, ice/heat application, home exercise program. Currently, the injured worker complains of back with radiation to the bilateral upper extremities. The plan of care was for physical therapy and a follow up appointment at a later date.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Eighteen additional physical therapy 2-3 times a week 4-6 weeks for the lumbar spine as an outpatient:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** Eighteen additional physical therapy 2-3 times a week 4-6 weeks for the lumbar spine as an outpatient are not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines recommend up to 10 visits for this condition. The request exceeds this number. Furthermore, the documentation is not clear on how much therapy the patient has had prior to this request and the efficacy in regards to functional improvement. The request for eighteen additional physical therapy sessions is not medically necessary.