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| <b>Case Number:</b>   | CM15-0047323 |                              |            |
| <b>Date Assigned:</b> | 03/19/2015   | <b>Date of Injury:</b>       | 08/01/2012 |
| <b>Decision Date:</b> | 05/01/2015   | <b>UR Denial Date:</b>       | 03/03/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 03/12/2015 |

### 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, North Carolina  
 Certification(s)/Specialty: Family Practice

### 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 41-year-old male, who sustained an industrial injury on 8/01/2012. The mechanism of injury was not noted. The injured worker was diagnosed as having chronic intractable low back pain, lumbar degenerative disc disease, lumbar spine disc herniations, radiculitis of the bilateral lower extremities, neuropathic pain, bilateral hip greater trochanteric bursitis, and depression. Treatment to date has included conservative measures, including diagnostics, acupuncture, psychology, and medications. Currently, the injured worker complains of neck and back pain, rated 8/10. He reported improvement with rest and medications. Exam of the cervical spine noted positive Spurling's test. Exam of the lumbar spine noted tenderness in the paralumbar musculature, positive straight leg raise test in bilateral lower extremities, diminished sensation over the L4, L5, and S1 dermatomes, and tenderness over the bilateral greater trochanteric bursa. Current medications were not noted. The treatment plan included acupuncture. The reason for the requested physical therapy was not noted. The PR2 report, dated 1/09/2015, noted lumbar pain with radicular symptoms and current medications as Vimovo. Physical therapy to the low back, 2-3 times weekly for 6 weeks, was recommended. A home exercise program was not documented at that time.

### 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 for the Lumbar Spine: Upheld**

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

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

**Decision rationale:** This patient suffered an injury to his low back in a 2012 accident. His diagnoses include lumbar degenerative disc disease, radiculitis and chronic intractable back pain. Request is made for physical therapy to the back three times a week for 6 weeks. The MTUS states that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of treatment. There is no supporting documentation for a change in symptoms or objective findings. MTUS does recommend physical therapy to treat a problem acutely; however this injury occurred approximately 3 years ago. There is also no documentation that home exercises have been tried and failed. This request is thus deemed not medically necessary.