

<b>Case Number:</b>	CM14-0146128		
<b>Date Assigned:</b>	09/12/2014	<b>Date of Injury:</b>	06/27/2012
<b>Decision Date:</b>	10/14/2014	<b>UR Denial Date:</b>	08/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/09/2014

### 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 Texas. 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 56 year old female who reported a date of injury of 06/21/2012. The mechanism of injury was reported as a pulling injury. The injured worker had diagnoses of sprain/strain of the lumbar spine and lumbar disc bulge with radiculitis, status post epidural injection. Prior treatments included physical therapy and chiropractic treatments and an epidural injection of unknown date. The injured worker had an MRI of the lumbar spine of unknown date with unofficial findings indicating grade 1 spondylethesis of L4 on L5, disc herniation at L4/L5, L5/S1 with disc space narrowing and IVF encroachment. Surgeries were not indicated within the medical records received. The injured worker had complaints of intermittent lower lumbar pain with the pain shooting down the right lower extremity and rated the pain 6-7/10 with the pain increasing with activity, numbness and tingling of the right lower extremity, pain of the hands bilaterally and, frequent tremor and twitches in the lower extremities bilaterally. The clinical note dated 08/27/2014 noted the injured worker had pain and tenderness to the lumbar spine, right S/I and right piriformis and difficulty standing more than a minute at a time. The injured worker had a positive Bechterew's on the right and a positive sitting roots test on the right and was unable to perform heel and toe walking, The injured worker's range of motion of the lumbar spine was 65 degrees of flexion, 15 degrees of extension, 20 degrees of right and left lateral bending and, 20 degrees of right and left rotation. Medications included Relafen. The treatment plan included the physician's recommendation for post epidural injection physiotherapy with cores stabilization and work conditioning, pain management reevaluation, orthopedic spine evaluation and a home exercise program with core stabilization. The rationale and request for authorization form were not included within the medical records provided.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physiotherapy 2 x 4 lumbar spine.:** Upheld

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

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

**Decision rationale:** The request for physiotherapy 2x4 lumbar spine is not medically necessary. The injured worker had complaints of intermittent lower lumbar pain with the pain shooting down the right lower extremity and rated the pain 6-7/10 with the pain increasing with activity, numbness and tingling of the right lower extremity, pain of the hands bilaterally and, frequent tremor and twitches in the lower extremities bilaterally. The California MTUS guidelines note 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. Active therapy requires an internal effort by the individual to complete a specific exercise or task. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. The guidelines recommend 9-10 visits over 8 weeks while allowing for fading of treatment frequency from up to 3 visits per week to 1 or less, plus an active self-directed home exercise program. It is noted the injured worker completed prior physical therapy; however, there is a lack of documentation indicating the injured worker benefited from the therapy with documented improvements in range of motion, strength, and functional mobility improvements, to warrant additional therapy. The documentation does not indicate how many sessions of physical therapy have been performed. As such, the request is not medically necessary.