

<b>Case Number:</b>	CM14-0148824		
<b>Date Assigned:</b>	09/18/2014	<b>Date of Injury:</b>	12/10/2011
<b>Decision Date:</b>	10/30/2014	<b>UR Denial Date:</b>	09/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/12/2014

### 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 Orthopedic Surgery 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 43-year-old female who reported an injury on 12/10/2011 after a fall. The injured worker reportedly sustained an injury to her low back. The injured worker's treatment history included physical therapy, chiropractic care, epidural steroid injections, medications, a TENS unit, a home exercise program and cognitive behavioral therapy. The injured worker was evaluated on 08/26/2014. It was documented that the injured worker had 50% to 60% pain relief while using her TENS unit. However, when the unit was turned off pain relief discontinued. The injured worker's medications included Benadryl 50 mg at night as needed, Percocet 10/325 mg 2 tablets per day, Soma 350 mg 2 to 3 tablets per day. Physical findings included positive straight leg raising test, positive Faber test and decreased sensation in the L5 left lower extremity distribution. A request was made for 3 sessions of physical therapy to attempt lumbar traction. It was noted that the next step of treatment would be a home unit if the injured worker had a successful response to lumbar traction. A Request for Authorization form was not submitted to support the request.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy for lumbar spine #3:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310, Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**Decision rationale:** The requested physical therapy for the lumbar spine #3 is not medically necessary or appropriate. The clinical documentation indicates that the requested physical therapy is to supervise initiation of traction therapy for the injured worker. American College of Occupational and Environmental Medicine does not support the use of traction for lumbar spine conditions. There are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. As the injured worker is not a candidate for traction and is participating in a home exercise program, the need for additional physical therapy is not supported. As such, the requested physical therapy for the lumbar spine #3 is not medically necessary or appropriate.