

<b>Case Number:</b>	CM14-0218457		
<b>Date Assigned:</b>	01/08/2015	<b>Date of Injury:</b>	06/29/1990
<b>Decision Date:</b>	03/10/2015	<b>UR Denial Date:</b>	11/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/30/2014

### 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. 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, Washington

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 70-year-old male who reported an injury on 06/30/2003. The mechanism of injury involved a fall. The injured worker presented on 11/10/2014 for a physical therapy re-evaluation. The injured worker reported constant pain rated 4/10 to 8/10 across the lower back and into the bilateral lower extremities. The injured worker reported sleep disturbance, difficulty with balance, activity limitation, and a walking tolerance of only 5 minutes. Upon examination, there was stiffness and pain throughout the lumbar spine with diminished motor strength and tenderness to palpation. Active range of motion of the lumbar spine exhibited about 10% active mobility in all planes and was limited due to pain. Treatment recommendations included additional physical therapy impairments and further disability. Rehabilitative therapy was recommended at a frequency of 2 visits per week with an expected duration of 3 weeks.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**6 additional physical therapy sessions for the lumbar and/or sacral vertebrae, 2x3:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back

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

**Decision rationale:** California MTUS Guidelines state 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. The injured worker has participated in a previous course of physical therapy. There was no documentation of objective functional improvement. Therefore, additional treatment would not be supported. Given the above, the request is not medically appropriate.