

<b>Case Number:</b>	CM14-0218587		
<b>Date Assigned:</b>	01/08/2015	<b>Date of Injury:</b>	10/25/2010
<b>Decision Date:</b>	03/12/2015	<b>UR Denial Date:</b>	12/04/2014
<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, Arizona

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 47 year old male with a reported work related back injury dated 12/29/2011. The injured worker was diagnosed with lumbago. According to a physical therapy progress note dated 11/13/2014, the injured worker presented for physical therapy visit number 13 and reported improved mobility and strength and decreased pain with constant right lower extremity radiculopathy. Additional treatments have consisted of lumbar spine surgery, physical therapy, and medications. Diagnostic testing included x-ray of the sacroiliac joints on 11/03/2014 which showed stable right sacroiliac joint fusion and lumbar spine surgery without complications. It was noted that the injured worker was status post L5-S1 fusion with removal of hardware, as well as right SI joint fusion. Upon examination, there was an antalgic gait, 110 degrees flexion of the right hip, 30 degrees right hip abduction, 115 degrees left hip flexion, 4+/5 motor weakness, and intact sensation. Additional treatment at a frequency of 2 times per week for a duration of 6 weeks was recommended at that time.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Twelve (12) physical therapy sessions for the low back (2x6): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.  
Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**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. According to the documentation provided, the injured worker has been previously treated with physical therapy. There is no documentation of objective functional improvement following the initial course of treatment. The current request for 12 sessions of physical therapy would exceed guideline recommendations. As the medical necessity has not been established in this case, the request is not medically appropriate.