

<b>Case Number:</b>	CM15-0064868		
<b>Date Assigned:</b>	04/10/2015	<b>Date of Injury:</b>	01/16/2013
<b>Decision Date:</b>	05/11/2015	<b>UR Denial Date:</b>	03/18/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/06/2015

### 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, Indiana, New York  
Certification(s)/Specialty: Internal Medicine

### 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 51 year old male, who sustained an industrial injury on 1/16/2013. The injured worker was diagnosed as having low back pain, pain in extremity, lower and/or upper, lumbar radiculopathy, myofascial pain, and sleep issue. Treatment to date has included diagnostics, transcutaneous electrical nerve stimulation unit, home exercise program, psychology, back support, acupuncture, and medications. Currently, the injured worker complains of low back pain with radiation to the left lower extremity, with intermittent numbness and tingling. He was currently working full time. Pain was increased with work and cold weather and improved with rest, transcutaneous electrical nerve stimulation unit, heating pad, medications, and back support. Physical therapy was requested due to limited range of motion and persistent pain.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy one time per week for 6-8 weeks lumbosacral/thoracic:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Section, Physical Therapy.

**Decision rationale:** Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, physical therapy one time per week times 6 to 8 weeks to the lumbosacral spine and thoracic spine is not medically necessary. Patients should be formally assessed after a six visit clinical trial to see if the patient is moving in a positive direction, no direction or negative direction (prior to continuing with physical therapy). When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted. In this case, the injured worker's working diagnoses are lower back pain; lower and/or upper extremity pain; lumbar radiculopathy; myofascial pain; and sleep issue. The earliest progress notes in the medical record dated my August 29, 2014 indicates the injured worker was already engaged in a home exercise program. The worker uses a TENS unit. There are no physical therapy progress notes. The injured worker has returned to work full-time. Subjectively, pursuant to a March 4, 2015 progress note, the worker complains of continued low back pain that radiates to the left lower extremity with intermittent numbness and tingling. The radicular symptoms are worse for the last three weeks each worker works eight hours a day five days a week. Objectively, there is tenderness palpation of the lumbar spine with decreased range of motion. There is no documentation home exercise program was not providing overall benefit to the injured worker nor was there any indication physical therapy would provide any additional benefit over and above that available to the injured worker through the home exercise program. Additionally, there were no subjective or objective complaints involving the thoracic spine. Consequently, absent compelling clinical documentation with subjective and objective complaints involving the thoracic spine and compelling clinical facts to warrant additional physical therapy, physical therapy one time per week times 6 to 8 weeks to the lumbosacral spine and thoracic spine is not medically necessary.