

<b>Case Number:</b>	CM15-0068194		
<b>Date Assigned:</b>	04/15/2015	<b>Date of Injury:</b>	05/14/2008
<b>Decision Date:</b>	06/11/2015	<b>UR Denial Date:</b>	03/12/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/10/2015

### 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: Pennsylvania, Ohio, California  
 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 36 year old male, who sustained an industrial injury on 05/14/2008. He has reported subsequent neck, back and lower extremity pain and was diagnosed with lumbago, sciatica and chronic pain syndrome. Treatment to date has included oral and topical pain medication, sacroiliac joint injection and physical therapy. In a progress note dated 02/17/2015, the injured worker complained of back pain that was rated as 4-5/10 with medication and 7/10 without medication. Objective findings were notable for tenderness over the L5-S1 facet region, decreased lumbar range of motion, pain with range of motion, tenderness to palpation of the right hip and a palpable semi-mobile mass over the iliac crest on the right at the L4 region. A request for authorization of 8 sessions of physical therapy to the low back and right hip was made.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy, once weekly for 8 weeks, low back/right hip, per 3/5/15 order: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 25, Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99, Postsurgical Treatment Guidelines Page(s): 23.

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

**Decision rationale:** MTUS encourages physical therapy with an emphasis on active forms of treatment and patient education. This guideline recommends transition from supervised therapy to active independent home rehabilitation. Given the timeline of this injury and past treatment, the patient would be anticipated to have previously transitioned to such an independent home rehabilitation program. The records do not provide a rationale at this time for additional supervised rather than independent rehabilitation. This request is not medically necessary.