

|                       |              |                              |            |
|-----------------------|--------------|------------------------------|------------|
| <b>Case Number:</b>   | CM13-0008579 |                              |            |
| <b>Date Assigned:</b> | 09/12/2013   | <b>Date of Injury:</b>       | 02/28/2012 |
| <b>Decision Date:</b> | 01/10/2014   | <b>UR Denial Date:</b>       | 07/09/2013 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 08/08/2013 |

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation and Pain Medicine, and is licensed to practice in California, Texas, and Ohio. 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 physician 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 patient is a 60-year-old female who reported an injury on 01/14/2012. The mechanism of injury was not specifically stated. The patient was diagnosed with a cervical spine sprain, right shoulder sprain, left upper extremity radiculopathy, lumbar spine disc protrusion, lumbar spine radiculopathy, right knee internal derangement, myospasms and cervical spine multilevel disc bulges. The patient was most recently seen by [REDACTED] on 06/14/2013. The patient complained of persistent low back, neck and right knee pain as well as urinary incontinence. Physical examination revealed tenderness to palpation of the left upper trapezius muscles and suboccipitals, positive Spurling's maneuver, tenderness to palpation with spasm of the paraspinals, tenderness to palpation of the sacroiliacs, limited lumbar range of motion, decreased sensation to light touch of the right lateral thigh and positive straight leg raise. Additionally the physical examination revealed tenderness to palpation of the right AC joint, tenderness to palpation with spasm of the right upper trapezius muscle, positive crepitus, tenderness to palpation of the right wrist with full range of motion, tenderness to palpation of the right greater trochanter with limited range of motion secondary to pain, tenderness to palpation of the right infrapatellar region of the left lateral knee as well as the right knee popliteal fossa, full range of motion, and positive McMurray's testing bilaterally with crepitus and intact sensation of the bilateral lower extremities. The treatment plan included an MR arthrogram of the right knee, a right knee brace, a right knee insole and prescriptions for Neurontin, Baclofen and Omeprazole.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**12 physical therapy/CMT sessions: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** The Physician Reviewer's decision rationale: The 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 and range of motion and can alleviate discomfort. Patients are instructed and expected to continue active therapy at home as an extension of the treatment process. Guidelines allow for a fading of treatment frequency plus active, self-directed home physical medicine. As per the clinical notes submitted, the patient complained of persistent pain in the lower back, neck and right knee. Physical examination revealed musculoskeletal deficits in multiple areas, including the cervical and lumbar spine, right shoulder and right knee. It is unknown as to whether the request for 12 physical therapy sessions is for the knee, shoulder, cervical spine or lumbar spine. A previous utilization review report was submitted on 07/09/2013. A request for additional information was submitted at that time. The requested information has yet to be received. The request for 12 physical therapy/CMT sessions is not medically necessary and appropriate.

**1 FCE/ROM: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Fitness for Duty Chapter, Online Edition..

**Decision rationale:** The Physician Reviewer's decision rationale: California MTUS/ACOEM Practice Guidelines state In order for an injured worker to stay at or return successfully to work, he or she must be physically able to perform some necessary job duties. This does not necessarily mean that the worker has fully recovered from the injury, or is pain-free; it means that the worker has sufficient capacity to safely perform some job duties. Known as functional recovery, this concept defines the point at which the worker has regained specific physical functions necessary for reemployment. The Official Disability Guidelines state an FCE should be considered when there are previous unsuccessful return to work attempts; there is conflicting medical reporting on precautions and/or fitness for a modified job; there are injuries that require detailed exploration of a worker's abilities; the patient is close to Maximum Medical Improvement; and/or there are additional or secondary conditions clarified. As per the clinical notes submitted, the medical rationale for the requested service was not provided. There is no evidence of a failure to return to work. A previous utilization review report was submitted on 07/09/2013. Additional information was requested at that time but requested information has yet to be received. The request for 1 FCE/ROM is not medically necessary and appropriate.

