

<b>Case Number:</b>	CM13-0021654		
<b>Date Assigned:</b>	07/02/2014	<b>Date of Injury:</b>	05/22/2003
<b>Decision Date:</b>	07/31/2014	<b>UR Denial Date:</b>	08/28/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/09/2013

### 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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation, and is licensed to practice in Illinois. 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/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 injured worker is a 59-year-old female with a reported injury on 05/22/2003. The mechanism of injury was not provided within the clinical notes. The clinical note dated 09/17/2013 reported that the injured worker complained of neck, bilateral shoulder, and low back pain. The physical assessment reviewed positive cervical compression to the left. Positive Jackson's sign to the left with restricted cervical range of motion. Bilateral shoulders positive apprehension test. It was reported that the injured worker had decreased sensation on the C5 dermatome, left greater than right. The injured worker's diagnoses included fibromyalgia, derangement to bilateral knees, cervicogenic headaches, and derangement to right shoulder. The injured worker's prescribed medication regimen was not provided within the clinical notes. The provider requested physical therapy for the injured worker's cervical and lumbar spine. The rationale was not provided within the clinical notes. The Request for Authorization was submitted on 09/04/2013. The injured worker's prior treatments were not provided within the clinical notes.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy, two (2) times a week for four (4) weeks, to cervical spine:** Upheld

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

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

**Decision rationale:** The injured worker complained of neck, bilateral shoulder, and low back pain. The treating physician's rationale for lumbar physical therapy was not provided within the clinical notes. The CA MTUS guidelines recognize active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. Within the provided documentation, an adequate and complete assessment of the injured worker's functional condition was not provided; there is a lack of documentation indicating that the injured worker has significant functional deficits. Given the information provided, there is insufficient evidence to determine the appropriateness of lumbar spine physical therapy; therefore, the request is non-certified.

**Physical therapy, two (2) times a week for four (4) weeks, to lumbar spine:** Upheld

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

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

**Decision rationale:** The injured worker complained of neck, bilateral shoulders, and low back pain. The treating physician's rationale for cervical spine physical therapy was not provided within the clinical notes. The CA MTUS guidelines recognize active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. Within the provided documentation, an adequate and complete assessment of the injured worker's functional condition was not provided; there is a lack of clinical documentation indicating that the injured worker has significant functional deficits. Given the information provided, there is insufficient evidence to determine the appropriateness of physical therapy to the cervical spine; therefore, the request is non-certified.