

<b>Case Number:</b>	CM13-0033058		
<b>Date Assigned:</b>	12/06/2013	<b>Date of Injury:</b>	10/27/2011
<b>Decision Date:</b>	04/18/2014	<b>UR Denial Date:</b>	09/18/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/09/2013

### 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 and Rehabilitation, has a subspecialty in Sports Medicine and is licensed to practice in Texas. 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 patient is a 31-year-old female who reported an injury on 10/27/2011. The mechanism of injury involved a fall. The patient is currently diagnosed with cervical disc protrusion, cervical myospasm, cervical pain, cervical radiculopathy, cervical sprain, cervical stenosis, lumbar annular tear, lumbar disc protrusion, lumbar muscle spasm, lumbar pain, lumbar radiculopathy, lumbar stenosis, left knee internal derangement, left knee sprain, plantar heel spur, and insomnia. The patient was recently seen by [REDACTED] on 10/09/2013. The patient reported persistent pain, with stiffness and weakness. The physical examination revealed decreased and painful range of motion of the cervical and lumbar spine, 3+ tenderness to palpation, palpable muscle spasm, positive Kemp's testing and positive straight leg raising. The patient also demonstrated decreased range of motion of the left knee with positive McMurray testing. Treatment recommendations included physical therapy three (3) times per week for four (4) weeks, twice per week for four (4) weeks, and once per week for four (4) weeks to increase range of motion and decrease pain.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PHYSICAL THERAPY, 3 TIMES A WEEK FOR 4 WEEKS, TO THE CERVICAL, THORACIC AND LUMBAR SPINE, LEFT KNEE AND BILATERAL FOOT:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL MEDICINE GUIDELINES Page(s): 99. Decision based on Non-MTUS Citation

Official Disability Guidelines (ODG);NECK AND UPPER BACK(UPDATED 05/14/2013), PHYSICAL THERAPY and LOW BACK - LUMBAR & THORACIC (ACUTE & CHRONIC) and KNEE & LEG, PHYSICAL MEDICINE TREATMENT,ANKLE & FOOT, PHYSICAL THERAPY (PT).

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

**Decision rationale:** The Chronic Pain Guidelines state that 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. The Guidelines allow for a fading of treatment frequency plus active self-directed home physical medicine. As per the documentation submitted, the patient has completed a previous course of physical therapy. However, there is no documentation of objective functional improvement. Therefore, ongoing treatment cannot be determined as medically appropriate. Additionally, there is no evidence of a comprehensive physical examination of bilateral feet. Based on the clinical information received and the California MTUS Guidelines, the request is non-certified.