

<b>Case Number:</b>	CM13-0050877		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	05/05/2010
<b>Decision Date:</b>	05/06/2014	<b>UR Denial Date:</b>	10/25/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/14/2013

### 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 Orthopedic Surgery, has a subspecialty in Orthopedics 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 injured worker is a 57-year-old male who reported an injury on 05/05/2010. The mechanism of injury was not provided. Current diagnoses include neuropathic pain of the right lower extremity, lumbar disc protrusion, lumbar facet arthropathy, bilateral sacroiliitis, cervical disc protrusion, status post laminectomy and discectomy, auto fused L5-S1, status post fall to the right knee, status post "interlumbar" laminotomy at L3 through L5, status post deep exploration of the lumbar spine, sympathetic mediated pain, status post right knee arthroscopy, chronic low back pain, herniated nucleus pulposus at C5-6 with stenosis, and bilateral upper extremity radiculopathy. The injured worker was evaluated on 10/02/2013. The injured worker reported persistent neck pain with associated numbness, tingling, and weakness. The injured worker also reported lower back pain with radiation to bilateral lower extremities and bilateral shoulder pain rated 7/10. Physical examination revealed tenderness to palpation over C5 through C7, weakness in the deltoid and biceps at 4/5, normal range of motion, positive cervical compression testing, 1+ deep tendon reflexes at the C5 and C6 dermatome and 2+ at the C7 bilaterally. Treatment recommendations at that time included continuation of physical therapy treatment for the cervical spine, lumbar spine, and right knee twice per week for 4 weeks.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PHYSICAL THERAPY 2XWK X 4WKS CERVICAL/LUMBAR SPINE, RIGHT KNEE:**  
Upheld

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

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

**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, range of motion, and can alleviate discomfort. Guidelines allow for a fading of treatment frequency plus active self-directed home physical medicine. There is no documentation of a previous course of physical therapy. Therefore, there is no evidence of objective functional improvement. As such, the request for additional physical therapy cannot be determined as medically appropriate. Therefore, the request for PHYSICAL THERAPY 2XWK X 4WKS CERVICAL/LUMBAR SPINE, RIGHT KNEE is non-certified.