

<b>Case Number:</b>	CM13-0051635		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	09/24/2012
<b>Decision Date:</b>	03/10/2014	<b>UR Denial Date:</b>	10/29/2013
<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 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 is licensed to practice in California. 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:

This is a female patient with a date of injury of 9/24/12. A utilization review determination dated 10/29/13 recommends modification of physical therapy 2x/week for 4 weeks, cervical spine to physical therapy 2x/week for 3 weeks, cervical spine. A supplemental report dated 10/10/13 identifies that the patient was seen on 10/7/13 and reported having finished PT to the left upper extremity and continuing with a self-guided home exercise program. Subjective complaints included left-sided neck pain radiating to the left shoulder and left upper extremity. Objective examination findings identify anterior head carriage with head tilt to the left and shoulder girdle unleveling with the right side elevated. There was left-sided tenderness over the paravertebral and upper trapezial musculatures with hypertonicity and muscle guarding. A tender myofascial trigger point was palpable. ROM was limited. There was slight decreased sensation in the left upper extremity in a diffuse manner with preference for a C6/median nerve distribution. Treatment plan recommended a course of physical therapy 2 x 4.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy 2x/week for 4 weeks for the cervical spine:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation ODG

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

**Decision rationale:** The MTUS Chronic Pain Guidelines support up to 10 physical therapy sessions in the management of conditions such as myalgia, myositis, and radiculitis. Within the documentation available for review, there is documentation of cervical spine pain radiating to the left upper extremity with deficits including limited range of motion and decreased sensation. There is no documentation of any recent physical therapy for the cervical spine. MTUS Chronic Pain Guidelines do support the proposed number of sessions in the management of this condition. In light of the above, the currently requested physical therapy 2x/week for 4 weeks, cervical spine is medically necessary and appropriate.