

<b>Case Number:</b>	CM13-0060399		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	03/07/2013
<b>Decision Date:</b>	03/26/2014	<b>UR Denial Date:</b>	10/30/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/03/2013

### 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 Neurology, has a subspecialty in Neuromuscular Medicine, 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:

██████████ is a 70 year old woman with past medical history of diabetes who sustained a work related injury on March 7 2013. Subsequently, she developed that chronic back and neck pain. According to a progress note dated October 22, 2013 the patient had persistent cervical and lumbar pain. Her physical examination demonstrated the limited bilateral shoulder range of motion. The patient was diagnosed with cervical sprain, lumbar sprain, left shoulder rotator cuff, left wrist sprain and lower extremity radiculopathy. The patient was treated with naproxen and tramadol and physical therapy. Her provider requested authorization for 4 weeks of physical therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy (2 x 4 weeks) for the cervical and lumbar:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99. Decision based on Non-MTUS Citation Restoration of Function Chapter (ACOEM Practice Guidelines, 2nd Edition (2004)) pg. 114.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Programs (functional restoration programs) Page(s): 31-33.

**Decision rationale:** Outpatient pain rehabilitation programs may be considered medically necessary when all of the following criteria are met: 1) An adequate and thorough evaluation has been made, including baseline functional testing so follow-up with the same test can note functional improvement; (2) Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement; (3) The patient has a significant loss of ability to function independently resulting from the chronic pain; (4) The patient is not a candidate where surgery or other treatments would clearly be warranted (if a goal of treatment is to prevent or avoid controversial or optional surgery, a trial of 10 visits may be implemented to assess whether surgery may be avoided); (5) The patient exhibits motivation to change, and is willing to forgo secondary gains, including disability payments to effect this change; & (6) Negative predictors of success above have been addressed. There is no documentation about the effect of previous treatment with physical therapy. Furthermore, there is no documentation of the objectives and goals of the prescribed physical therapy. There is no clear justification of the length and frequency of prescribed physical therapy. Therefore, the prescription of physical therapy (2x4 weeks) for the cervical and lumbar is not medically necessary until more information is available.