

<b>Case Number:</b>	CM14-0019576		
<b>Date Assigned:</b>	04/23/2014	<b>Date of Injury:</b>	06/21/2013
<b>Decision Date:</b>	07/03/2014	<b>UR Denial Date:</b>	02/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/17/2014

### 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 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 61-year-old female who reported an injury on 06/21/2013. The mechanism of injury was not stated. Current diagnoses include thoracic spine strain, lumbar spine strain, right lumbar radiculopathy, left rotator cuff tendonitis and impingement syndrome and history of probable right great toe fracture. The injured worker was evaluated on 01/09/2014. The injured worker reported a flare up of pain in the lower back with increased activity. Physical examination revealed tenderness to palpation of the cervical, thoracic, and lumbar spine. The injured worker also demonstrated limited lumbar range of motion, positive straight leg raising, and decreased sensation in the right lower extremity at the L5 distribution. Treatment recommendations at that time included 12 additional physical therapy visits.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PHYSICAL THERAPY ON THORACIC/LUMBAR:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NECK AND UPPER BACK COMPLAINTS.

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

**Decision rationale:** 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. Treatment for unspecified myalgia and myositis includes 9-10 visits over 8 weeks. There is no quantity listed in the current request. There is also no documentation of objective functional improvement following an initial course of physical therapy. Based on the clinical information received and the California MTUS Guidelines, the request is not medically necessary and appropriate.