

<b>Case Number:</b>	CM14-0114945		
<b>Date Assigned:</b>	08/04/2014	<b>Date of Injury:</b>	01/02/2007
<b>Decision Date:</b>	09/17/2014	<b>UR Denial Date:</b>	07/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/22/2014

### 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 49-year-old female who reported an injury due to repetitive trauma on 01/02/2007. On 06/25/2014, her diagnoses included status post right shoulder arthroscopic sub acromial decompression in 06/2013, lumbar disc protrusion with radiculopathy, cervical pain, right wrist/hand pain, and rule out release of the pedicle maintained pain syndrome of the upper right extremity. Her complaints included right shoulder pain rated 7/10, cervical pain greater on the right than on the left rated 5/10, right wrist/hand pain rated 5/10, low back pain greater on the left than on the right rated 5/10, that she was not able to sit for longer than 20 minutes continuously, and insomnia. She reported that her medications enabled greater function and activity level. She reported a significant decrease in pain with her medications. Her medications included Tramadol ER 150mg, hydrocodone/APAP 10/32 mg, Naproxen 550mg, pantoprazole 20 mg, and Orphenadrine 100mg. The treatment plan included closely monitoring all of her medications and a new prescription for Ambien 10 mg at bedtime. There was no rationale or Request for Authorization included in this injured worker's chart.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy for lumbar spine (visits) QTY: 8:** Upheld

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

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

**Decision rationale:** The Expert Reviewer based his/her decision on the MTUS Chronic Pain Medical Treatment Guidelines, Physical Medicine, pages 98-99. The Expert Reviewer's decision rationale: The request for physical therapy for lumbar spine, visits quantity 8, is not medically necessary. The California MTUS Guidelines recommend "active therapy for restoring flexibility, strength, endurance, function, range of motion, and to alleviate discomfort." The recommendation for myalgia and myositis is 9 to 10 visits over 8 weeks. Although this worker has a diagnosis of lumbar disc protrusion with radiculopathy and had complaints of low back pain, there was no documentation of functional deficits due to her low back pain. Therefore, this request for physical therapy for lumbar spine, visits quantity 8, is not medically necessary.