

<b>Case Number:</b>	CM14-0135522		
<b>Date Assigned:</b>	08/29/2014	<b>Date of Injury:</b>	03/18/2014
<b>Decision Date:</b>	10/02/2014	<b>UR Denial Date:</b>	08/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/21/2014

### 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 & 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 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 56-year-old male who sustained injuries on March 18, 2014. He missed a step and fell while on a ladder. Medical records dated July 10, 2014 document that the injured worker complained of continued and constant cervical spine pain with radiation to the right upper extremity with pain rated at 8/10. He also complained of lumbosacral pain with radiation to the right anterior lower extremity over the anterior thigh to the anterior leg rated at 8/10. He also complained of hip pain rated at 5-7/10. The pain was made worse with prolonged standing and sitting. Cervical range of motion was limited with crepitus and muscular hypertonicity and tenderness. Sensation was decreased in the right anterior lateral arm and forearm. Grip strength was decreased in the right upper extremity. Bilateral shoulder range of motion was limited and was considered as moderate. Impingement sign was positive on the right. Rotator cuff was also positive on the right. Lumbosacral examination noted pain and decreased range of motion in the right anterolateral thigh. Sensation was decreased over the thigh and over the dorsal foot. Straight leg raising test was positive on the right. Moderate loss of range of motion in all planes was noted. Right knee examination noted loss of range of motion. Most recent progress notes dated August 11, 2014 indicated that the injured worker complained of persistent neck, mid back, low back, bilateral shoulder and bilateral hip pain, all rated at 8/10 and right wrist pain rated at 6/10, which was frequent and the same. He reported that his medication helped decrease his pain from 8/10 down to 5/10. He reported that therapy made him better including medications, chiropractic, massage, and heat. Pain was made worse with sitting still and lifting. On examination, the cervical spine range of motion was limited with crepitus and muscular hypertonicity and tenderness. Bilateral shoulder examination noted decreased range of motion which was considered as moderate. Positive impingement sign and positive rotator cuff syndrome were noted on the right. Lumbosacral examination noted decreased moderate range of

motion. Sensation was decreased over the thigh and dorsal aspect of the foot. Straight leg raising test was positive on the right. Right knee examination noted slight range of motion and positive McMurray's sign. He was diagnosed with (a) cervical spine rule out disc herniation; (b) history of cervical fracture location unknown; (c) lumbosacral strain with history of compression fracture rule out radiculopathy; (d) bilateral shoulder pain, rule out internal derangement and rule out rotator cuff syndrome; (e) right knee strain, rule out meniscal injury.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Physical therapy 12 visits (2x's weekly for 6 weeks): 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:** Per the medical records dated June 12, 2014, it is documented that the injured worker has received prior initial physical therapy with an unknown total number of sessions including light massage and most recent medical records indicate that he experienced improvements. However, thorough review of the presented medical records do not indicate any functional improvements secondary to the initial physical therapy sessions and the decrease in pain levels were attributed to oral medications. Evidence-based guidelines mandate that there should be documentation of significant decrease in pain levels as well as significant functional improvements before requesting for additional physical therapy sessions. Due to the absence of such mandated findings the requested 12 physical therapy sessions twice weekly for six weeks is considered not medically necessary.