

<b>Case Number:</b>	CM14-0174798		
<b>Date Assigned:</b>	10/28/2014	<b>Date of Injury:</b>	02/22/2013
<b>Decision Date:</b>	12/04/2014	<b>UR Denial Date:</b>	10/09/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/22/2014

### 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 Occupational 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 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:

Patient is a 50 year-old male with date of injury 02/22/2013. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 08/04/2014, lists subjective complaints as pain in the upper, mid and low back. It was noted that the patient has previously completed physical therapy and acupuncture, but the quantity and dates of visits were not recorded. NCS of the peripheral nerves of the bilateral upper extremities performed on 08/25/2014 was unremarkable. MRI of the lumbar spine performed on 08/28/2014 was notable for mild spondylosis present at L3-S1 interspaces with disc space narrowing. Objective findings: Examination of the lumbar spine revealed tenderness to palpation over the paraspinal muscles, spinous processes, and mild guarding. Range of motion was restricted in all planes. There was no pain throughout the range of motion testing bilaterally. Diagnosis: Cervical spine strain/sprain, rule out herniated disc 2. Right and left shoulder pain secondary to chronic neck pain 3. Rule out cervical radiculopathy versus peripheral neuropathy 4. Rule out left wrist median nerve neuropathy 5. Thoracic spine strain/sprain 6. Lumbosacral spine strain/sprain, rule out herniated disc.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy 2x/wk x 6wks lumbar spine:** 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 Guidelines 9792.20 - 9792.26 Page(s): 58-60.

**Decision rationale:** The MTUS Chronic Pain Medical Treatment Guidelines state that 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. Continued physical therapy is predicated upon demonstration of a functional improvement. There is no documentation of objective functional improvement. Physical therapy 2x/wk x 6wks lumbar spine is not medically necessary.