

<b>Case Number:</b>	CM14-0042538		
<b>Date Assigned:</b>	06/20/2014	<b>Date of Injury:</b>	10/20/2010
<b>Decision Date:</b>	07/24/2014	<b>UR Denial Date:</b>	02/27/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/13/2014

### 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 Physician Medicine and Rehabilitation, has a subspecialty in Interventional Spine 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 patient is a 51-year old with an injury date on 10/20/10. Based on the 1/6/14 progress report provided by [REDACTED] the diagnoses are: 1. sprain hip and thigh ACS (right)2. lower back pain3. chronic pain4. myofascial pain syndrome5. cervicogenic headaches (bilateral, right > left)6. rotator cuff synd nos/impingement (right)7. left shoulder subscapularis tendinopathyMost recent exam of lumbar-spine on 1/6/14 showed "Faber test positive. More difficult to balance on right leg. According to the examination of Cervical-spine on 10/25/13, showed restricted range of motion especially right and left lateral bending limited to 30 degrees. There was tenderness to palpation at paracervical muscles, rhomboids, trapezius, and SCM (Sternocleidomastoid) muscle on right. By examination of right shoulder on 10/25/13 showed restricted range of motion with internal rotation limited to 110 degrees, Hawkins test positive, Neer test was negative, and there was tenderness to palpation in periscapular muscles, rhomboids, trapezius. [REDACTED] is requesting physical therapy 8 visits (2x/week x 4 weeks). The utilization review determination being challenged is dated 2/27/14. [REDACTED] is the requesting provider, and he provided treatment reports from 10/25/13 to 1/16/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy 8 visits (2x/week x 4 weeks) lumbar spine: Overturned**

**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 Medical Treatment Guidelines, Physical Medicine Guidelines, pages 98-99.

**Decision rationale:** Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process.

Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistant devices. Patient-specific hand therapy is very important in reducing swelling, decreasing pain, and improving range of motion in CRPS(complex regional pain syndrome) . In a large case series of patients with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. This patient presents with chronic lower back pain likely second to SI(Sacroiliac) joint, hip pain, neck and shoulder pain related to myofascial pain and is status/post left knee arthroscopy from 2009. According to the physical request, the physical therapy 8 visits (2x/week x 4 weeks) on 1/6/14 was needed for strengthen hip stabilizing muscles and lumbar paraspinal muscles as well as improving range of motion of right hip joint. Review of the reports do not show any recent physical therapy being done in the past. The MTUS guidelines pages 98-99 allows for 8-10 sessions of physical therapy for various myalgias and neuralgias. Therefore the Physical Therapy 8 visits is medically necessary.

