

<b>Case Number:</b>	CM14-0074883		
<b>Date Assigned:</b>	07/16/2014	<b>Date of Injury:</b>	11/13/1995
<b>Decision Date:</b>	08/22/2014	<b>UR Denial Date:</b>	05/20/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/22/2014

### 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 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 a 59-year-old female who reported an injury on 11/13/1995. The mechanism of injury was noted to be a slip and fall. The injured worker was noted to have treatments of physical therapy, epidural steroid injection, and medications. Her diagnoses were noted to be chronic neck pain, status post cervical surgery, and status post shoulder surgery. A Primary Treating Physician's Progress Report dated 05/09/2014 noted the injured worker rating pain an 8/10 without medications and a 2/10 to 3/10 with medications. The evaluation noted active range of motion of the cervical spine is about 50% of normal in all directions. The injured worker had pain at the end of range of motion. She had a negative Spurling's sign, motor strength was 5/5 and equal in the upper extremities, sensation was intact and equal in the upper extremities. Myofascial trigger points were noted bilaterally in the neck and shoulder girdle right greater than left. She had pain with supraspinatus testing on the right, impingement sign was positive on the right. The treatment plan included medications, physical therapy, and a local steroid subacromial injection. The provider's rationale for the request was provided within the documentation. A Request for Authorization for medical treatment was not provided within the documentation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**8 Physical Therapy Sessions:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation Page(s): 114,Chronic Pain Treatment Guidelines Page(s): 98-99.

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

**Decision rationale:** The California Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines recommend physical medicine. 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. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual, and/or tactile instruction. 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 assistive devices. The physical medicine guidelines allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active, self-directed home physical medicine. The guidelines allow up to 10 visits over 8 weeks. According to the Primary Treating Physician's Progress Report the injured worker experienced pain with range of motion; however, it is not documented what type of range of motion the injured worker is being evaluated for. The physical exam does not provide an adequate assessment for motor strength. In addition, it is not noted in the physical exam the objective functional deficits. The injured worker has had prior therapy. It is noted that the prior therapy was efficacious for the injured worker. The guidelines allow for fading of treatment frequency and recommend home exercise. The provider's request for physical therapy fails to indicate the duration for the request of 8 sessions. In addition, the request fails to note what region of the body would be receiving the therapy. As such, the request for 8 physical therapy sessions is not medically necessary and appropriate.