

<b>Case Number:</b>	CM14-0075233		
<b>Date Assigned:</b>	07/16/2014	<b>Date of Injury:</b>	11/23/2011
<b>Decision Date:</b>	09/16/2014	<b>UR Denial Date:</b>	04/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/23/2014

### 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:

The patient is a 66-year-old female who has submitted a claim for tear of rotator cuff associated with an industrial injury date of 11/23/2011. Medical records from 2013 to 2014 were reviewed and showed that patient complained of intermittent moderate low back pain radiating to both thighs, left more than the right. Patient ambulates with an antalgic gait. Physical examination of the cervical spine revealed tenderness in the bilateral trapezius musculature. Some guarding was noted one examination. Physical examination of the lumbosacral spine revealed tenderness about the paralumbar musculature and positive for muscle spasms. Treatment to date has included surgery, activity modifications, medications and physical therapy. Utilization review dated 04/28/2014 denied the request for Physical Therapy for the lumbar spine two (2) times a week for four (4) weeks because recent progress reports indicate improvement in both knee pain and low back pain for this patient. An exacerbation was not documented. There is no indication this patient is not able to perform an effective home exercise program. The rationale for additional supervised therapy is not apparent.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy for the lumbar spine two (2) times a week for four (4) weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine.

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

**Decision rationale:** As stated on page 98 to 99 of CA MTUS Chronic Pain Medical Treatment Guidelines, physical therapy is beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. In this case, patient has authorized 12 sessions of physical therapy, however it is not clear in the documentation submitted if patient completed the certified sessions. Furthermore, there is no objective evidence of functional improvement from previous physical therapy. Therefore, the request for Physical Therapy for the lumbar spine two (2) times a week for four (4) weeks is not medically necessary.