

<b>Case Number:</b>	CM14-0075570		
<b>Date Assigned:</b>	07/16/2014	<b>Date of Injury:</b>	07/19/2011
<b>Decision Date:</b>	08/27/2014	<b>UR Denial Date:</b>	05/15/2014
<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 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 male who reported an injury on 07/19/2011. The mechanism of injury was a bicycle accident. The injured worker's prior treatments were noted to be medication and occupational therapy. His diagnoses were noted to be cervical myelopathy. The progress note dated 05/07/2014 indicated the injured worker to be in occupational therapy. The objective findings provide pain level at 6/10. Range of motion is full in the right upper extremity and full in the left upper extremity with burning and tingling. Functional upper extremity strength on the right is 4 and on the left 4+. Education was provided regarding the treatment plan. The treatment plan included therapy exercise, manual therapy, self care/activities of daily living management, electrical stimulation, therapeutic activity, home exercise program, functional electrical stimulation, edema control, range of motion exercises, strength training, and stretching exercises. The recommendation is to continue therapy once a week x90 days. 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:

**Retro Evaluation & Occupational Therapy 12 visits:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical therapy treatment.

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

**Decision rationale:** The California 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. 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. The injured worker's range of motion and functional strength was not significantly impaired according to the objective findings on a progress note dated 05/07/2014. There is no objective data of functional deficits. In addition, the provider's request for 12 visits is an excess of the guidelines recommendations of up to 10. Therefore, the request for retro evaluation and occupational therapy 12 visits is non-certified.