

<b>Case Number:</b>	CM14-0212064		
<b>Date Assigned:</b>	01/02/2015	<b>Date of Injury:</b>	07/09/2014
<b>Decision Date:</b>	02/17/2015	<b>UR Denial Date:</b>	11/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/18/2014

### 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 Rehab 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:

This patient sustained an injury on 7/9/14 from a motor vehicle accident while employed by [REDACTED]. Request(s) under consideration include Physical Therapy 2x/wk x 6wks Cervical and Lumbar Spine. Diagnoses include Cervicalgia/ C5-6 disc herniation; post-concussion; and lower back pain. Conservative care has included medications, therapy modalities, cognitive rehab, and modified activities/rest. The patient continues to treat for chronic ongoing symptom complaints with poor cognitive functions and blurred vision, unchanged from previous visits. Report from the provider noted continued difficulty sleeping and pain at sternum when she leaned on the pillows or when the dog jumped on the chest; and neck pain rated at 10/10. Exam showed unchanged findings of diffuse decreased in range in all planes of the lumbar and cervical spine with painful movements; tenderness and spasm over paraspinal muscles and midline spine with abnormal proprioception and finger-to-nose testing. Medications list Dexilant, Aspirin, and Ventolin inhaler. CT scan of the brain dated 7/10/14 had no evidence for acute intracranial abnormality or fracture with chronic left maxillary sinus disease. MRI of the brain on 7/14/14 also had normal findings. The request(s) for Physical Therapy 2x/wk x 6wks Cervical and Lumbar Spine was non-certified on 11/19/14 citing guidelines criteria and lack of medical necessity.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy 2xwk x 6wks Cervical and Lumbar Spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck & Upper Back, Low Back

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

**Decision rationale:** CT scan of the brain dated 7/10/14 had no evidence for acute intracranial abnormality or fracture with chronic left maxillary sinus disease. MRI of the brain on 7/14/14 also had normal findings. The patient remained unable to work on the computer at home. Review indicated the patient has completed at least 9 PT sessions and 14 exercise sessions in the form of running, biking, and swimming. Physical therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. However, there is no clear measurable evidence of progress with the PT treatment already rendered including milestones of increased ROM, strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints, clinical findings, and functional status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. The Chronic Pain Guidelines allow for 9-10 visits of physical therapy with fading of treatment to an independent self-directed home program. It appears the employee has received significant therapy sessions without demonstrated evidence of functional improvement to allow for additional therapy treatments. There is no report of acute flare-up, new injuries, or change in symptom or clinical findings to support for formal PT in a patient that has been instructed on a home exercise program for this injury. Submitted reports have not adequately demonstrated the indication to support further physical therapy when prior treatment rendered has not resulted in any functional benefit. The Physical Therapy 2x/wk x 6wks Cervical and Lumbar Spine is not medically necessary and appropriate.