

<b>Case Number:</b>	CM15-0001473		
<b>Date Assigned:</b>	01/12/2015	<b>Date of Injury:</b>	12/21/2010
<b>Decision Date:</b>	03/11/2015	<b>UR Denial Date:</b>	12/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/05/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: California, Arizona  
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 58-year-old male who reported an injury on 12/21/2010. The mechanism of injury was not provided. On 08/28/2014, the injured worker presented for a followup. There was no significant improvement since the last exam. Upon examination of the left shoulder, there was decreased range of motion and a positive impingement sign. There was tenderness to palpation over the anterior shoulder. Examination of the thoracic spine noted tenderness to the paraspinal muscles with spasm. Examination of the lumbar spine revealed tenderness to palpation with spasm and restricted range of motion. The deep tendon reflexes were normal and symmetrical. There is reduced sensation to the right L5 dermatome distribution. There is a positive right sided straight leg raise noted. The diagnoses were lumbar radiculopathy and sprain/strain of the thoracic region. The provider recommended physical therapy 3 times a week for 4 weeks for the right lower extremity, lumbar, and thoracic spine. The provider's rationale was not provided for request. The Request for Authorization form was not included in the medical documents for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy 3 times a week for 4 weeks, right lower extremities/Lumbar/Thoracic Spine: 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:** The request for physical therapy 3 times a week for 4 weeks, right lower extremities/lumbar/thoracic spine is not medically necessary. The California MTUS Guidelines state that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, and range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. The guidelines recommend 10 visits of physical therapy over 4 weeks. There is no evidence of previous physical therapy sessions the injured worker participated in or the efficacy of those sessions. Additionally, there is a lack of documentation objective functional deficits noted on physical exam. There were no baseline measures to assess objective functional improvements during therapy. As such, medical necessity has not been established.