Case Number:	CM15-0144780		
Date Assigned:	08/05/2015	**Date of Injury:**	01/10/2013
Decision Date:	09/02/2015	**UR Denial Date:**	07/02/2015
Priority:	Standard	**Application Received:**	07/27/2015

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: North Carolina
Certification(s)/Specialty: Family Practice

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 is a 34 year old male with a January 10, 2013 date of injury. A progress note dated June 18, 2015 documents subjective complaints (neck pain rated at a level of 5 out of 10; throbbing pain to the right shoulder rated at a level of 4 to 5 out of 10; lower back pain that radiates into the right buttock and thigh; cramping of the right calf and numbness to the right heel; symptoms rated at a level of 7 to 8 out of 10), objective findings (decreased deep tendon reflexes at L4 and L5 bilaterally; cervical paraspinal muscle spasms; decreased and painful range of motion of the cervical spine; positive cervical compression and Adson's tests; right shoulder range of motion slowly improving; tenderness upon palpation of the posterolateral shoulder; lumbar paraspinal muscle spasms; loss of sensation in the L5 nerve distribution bilaterally and the L5-S1 nerve distribution on the right), and current diagnoses (cervical strain; status post arthroscopic repair of superior labrum anterior to posterior lesion, right shoulder; lumbosacral disc herniation; right greater than left lower extremity radiculopathy). Treatments to date have included shoulder surgery, magnetic resonance imaging of the cervical spine (August 5, 2014; showed small broad-based bulges at C3, C4, and C5-6 as well as multilevel desiccation), magnetic resonance imaging of the lumbar spine (showed broad-based disc herniation, central and indenting the anterior thecal sac at L5-S1), lumbar epidural steroid injection, physical therapy which helped symptoms, and medications. The treating physician documented a plan of care that included additional physical therapy for the neck and back.

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional Physical Therapy 3x5 Neck and Back: Upheld

Claims Administrator guideline: Decision based on MTUS 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 chronic pain medical treatment guidelines section on physical medicine states: Recommended as indicated below. Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. 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(s). 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. (Colorado, 2002) (Airaksinen, 2006) Patient-specific hand therapy is very important in reducing swelling, decreasing pain, and improving range of motion in CRPS. (Li, 2005) The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of patients with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment. (Fritz, 2007)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. Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks; Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2) 8-10 visits over 4 weeks; Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks; The requested amount of physical therapy is in excess of California chronic pain medical treatment guidelines. The patient has already completed a course of physical therapy. There is no objective explanation why the patient would need excess physical therapy and not be transitioned to active self-directed physical medicine. The request is not medically necessary.