

<b>Case Number:</b>	CM15-0189463		
<b>Date Assigned:</b>	10/01/2015	<b>Date of Injury:</b>	10/28/2002
<b>Decision Date:</b>	11/20/2015	<b>UR Denial Date:</b>	08/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/25/2015

### 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: Pennsylvania, Ohio, California  
 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:

This injured worker is a 56-year-old male who reported an industrial injury on 10-28-2002. His diagnoses, and or impressions, were noted to include: chronic cervical sprain-strain; probable right upper extremity radiculitis without radiculopathy; right shoulder bicipital tendinitis; lumbosacral sprain-strain with radiculitis of the right lower extremity, and multi-level lumbar degenerative disc disease; and chronic right sacroiliac joint sprain-strain. No current imaging studies were noted; magnetic resonance imaging of the cervical and lumbosacral spine were done on 3-7-2008. His treatments were noted to include: medication management with toxicology studies. The progress notes of 8-18-2015 reported: right knee aching and pain, rated 7 out of 10; stiffness with back-low back-lumbar pain, rated 8 out of 10; worsening right shoulder pain, rated 6 out of 10; cervical pain, rated 9 out of 10, that radiated into the bilateral arms; and that she continued to experience substantial benefit, about 90%, from the lowest dose of medications, with less nociceptive, neuropathic and inflammatory pain. The objective findings were noted to include: no apparent distress; positive right knee McMurray's test with popping and pain; abnormal proprioception sensations in the right upper extremity; positive Neer's, Hawkins, and cross arm abduction tests in his right shoulder; tenderness along the right shoulder acromioclavicular joint; right knee sub-patellar chondromalacia with guarding of his lateral motions, and grinding to passive range-of-motion testing; and increased myofascial pain with pain to palpation on the left-side facets. The physician's requests for treatment were noted to include. The Request for Authorization, dated 8-18-2015, was noted for physical therapy, for an acute exacerbation of chronic spinal pain. The Utilization Review of 8-27-2015 non-certified the request for physical therapy for the neck and lumbar spine.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Physical therapy, neck:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, and Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

**Decision rationale:** MTUS encourages physical therapy with an emphasis on active forms of treatment and patient education. This guideline recommends transition from supervised therapy to active independent home rehabilitation. Given the timeline of this injury and past treatment, the patient would be anticipated to have previously transitioned to such an independent home rehabilitation program. The records do not provide a rationale at this time for additional supervised rather than independent rehabilitation. This request is not medically necessary.

### **Physical therapy, lumbar:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004, and Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

**Decision rationale:** MTUS encourages physical therapy with an emphasis on active forms of treatment and patient education. This guideline recommends transition from supervised therapy to active independent home rehabilitation. Given the timeline of this injury and past treatment, the patient would be anticipated to have previously transitioned to such an independent home rehabilitation program. The records do not provide a rationale at this time for additional supervised rather than independent rehabilitation. This request is not medically necessary.