

<b>Case Number:</b>	CM15-0205015		
<b>Date Assigned:</b>	10/21/2015	<b>Date of Injury:</b>	06/28/2012
<b>Decision Date:</b>	12/03/2015	<b>UR Denial Date:</b>	10/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/19/2015

### 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  
 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 56 year old male with an industrial injury date of 06-28-2012. Medical record review indicates he is being treated for displacement of lumbar and cervical intervertebral disc without myelopathy, disorders of bursa and tendons in shoulder region and chronic pain syndrome. Subjective complaints (09-10-2015) included ongoing pain in the neck and left shoulder with radiation to the left arm. He also complained of pain in the lower back with radiation to the left leg. The pain was associated with tingling in the left hand and left foot, numbness in the left foot and weakness in the left leg. The pain was rated as 8 out of 10, 5 out of 10 at its best and 9 out of 10 at its worst. Average level of pain in the past seven days was rated as 6. Work status (09-10-2015) is documented as no lifting or carrying over 10 pounds and no bending, stooping, crouching, crawling or kneeling. Medications included Nabumetone and Omeprazole. Prior treatment included acupuncture (at least 4 treatments), therapy, and medications. Other prior treatments are not indicated in the submitted medical records. Physical exam (09-10-2015) documented tenderness to palpation over the bilateral cervical paraspinal muscles. Flexion was 50 degrees, extension 25 degrees, rotation 30 degrees to the right and left and side bending 20 degrees to the right and left. Left shoulder exam revealed range of motion to forward flexion 140 degrees, abduction 110 degrees, external rotation 40 degrees, internal rotation 50 degrees and extension 10 degrees. There was tenderness to palpation over the posterior aspect of the shoulder. Exam of the lumbar spine noted tenderness to palpation over the bilateral lumbar paraspinal muscles consistent with spasms. On 10-06-2015 the request for 10

additional physical therapy sessions for treatment of the cervical spine, left shoulder and lumbar spine was non-certified by utilization review.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Ten additional sessions of physical therapy, two days a week for five weeks for the cervical spine, left shoulder and lumbar spine:** Upheld

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

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

**Decision rationale:** Review indicates previous conservative treatment included 30 PT and acupuncture visits without specific functional improvement for this June 2012 injury. Time-limited care plan with specific defined goals, assessment of functional benefit with modification of ongoing treatment based upon the patient's progress in meeting those goals and the provider's continued monitoring of successful outcome is stressed by MTUS guidelines. 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. Submitted reports have no acute flare-up or specific physical limitations to support for physical/ occupational therapy. The Chronic Pain Guidelines allow for 9-10 visits of therapy with fading of treatment to an independent self-directed home program. The submitted reports have not identified clear specific functional improvement in ADLs, functional status, or decrease in medication and medical utilization from the formal physical therapy already rendered to support further treatment. There has not been a change in neurological compromise or red-flag findings demonstrated for PT at this time. Submitted reports have also not adequately identified the indication to support for excessive quantity of PT sessions without extenuating circumstances established beyond the guidelines. The Ten additional sessions of physical therapy, two days a week for five weeks for the cervical spine, left shoulder and lumbar spine is not medically necessary and appropriate.