

<b>Case Number:</b>	CM14-0131700		
<b>Date Assigned:</b>	09/19/2014	<b>Date of Injury:</b>	07/26/2013
<b>Decision Date:</b>	10/21/2014	<b>UR Denial Date:</b>	07/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/18/2014

### 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 & Rehabilitation, has a subspecialty in Pain Management and is licensed to practice in Texas & Oklahoma. 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:

The injured worker is a 24-year-old female who reported a work related injury on 07/26/2013 due to a slip and fall. The injured worker's diagnoses consist of contusion of the right hip, lumbar sprain, and left shoulder strain. Treatment has included physical therapy. Diagnostic studies include an x-ray of the left shoulder dated 07/23/2014 which showed no acute abnormalities. An x-ray was done on the date of 06/23/2014 of the lumbar spine that revealed decrease in normal lumbar lordosis. An MRI of the left shoulder was performed on 11/21/2013 which was noted to be normal. Upon examination on 07/24/2014, the injured worker complained of persistent left shoulder pain and low back pain. Upon examination of the lumbar spine and lower extremities, it was noted that the injured worker ambulated with normal gait. The injured worker stood with a normal lumbar lordosis. The crests of the ilium were parallel to the floor. There was slight tenderness in the lumbar paravertebral muscles. There were no spasms of the lumbar paravertebral muscle. There was no tenderness in the right and left sacroiliac joints bilaterally. Range of motion included flexion 60 degrees with increased low back pain, extension 10 degrees with increased low back pain, right and left lateral bending 25 degrees with increased low back pain. The straight leg raise was 50 degrees bilaterally without pain in the lower back region. There was no pain with palpation of the acromioclavicular joint, subacromial bursa, coracoid process, bicipital groove, or subdeltoid bursa. The impingement sign, Hawkins test, drop arm test were all negative. Range of motion of the shoulder was noted to be normal; however, there was pain and clicking with range of motion. The injured worker was noted to not take any medications. The treatment plan consisted of an MR arthrogram of the left shoulder and physical therapy twice a week for 4 weeks to the lumbar spine. The rationale for the request was not

submitted for review. A Request for Authorization form was submitted for review on 08/14/2014.

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

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

**Physical Therapy 2xwk x4wks lumbar:** 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- Low Back (updated 7/3/14) - Physical Therapy (PT)

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

**Decision rationale:** The California MTUS Guidelines state that up to 10 visits of physical therapy may be supported to promote functional gains in injured workers with unspecified neuritis. Additionally, the guidelines state 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. Within the clinical, there was no documentation outlining strength and range of motion deficits or details regarding the injured worker's past treatment history and previous physical therapy. The injured worker had physical therapy with no documentation provided to show evidence of progression. In the absence of documentation showing objective functional gains made with previous visits and exceptional factors to warrant additional visits beyond the guideline's recommendations, the request is not supported. As such, the request for physical therapy 2 times a week for 4 weeks for the lumbar spine is not medically necessary.