

<b>Case Number:</b>	CM15-0104827		
<b>Date Assigned:</b>	06/09/2015	<b>Date of Injury:</b>	07/22/2014
<b>Decision Date:</b>	07/10/2015	<b>UR Denial Date:</b>	04/30/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/01/2015

### 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: Maryland

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Neuromuscular Medicine

### 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 54 year old female, who sustained an industrial injury on 07/22/2014. She has reported injury to the neck, right shoulder, and low back. The diagnoses have included lumbosacral spondylosis without myelopathy; cervical spinal stenosis with right-sided radiculopathy; right shoulder impingement with some rotator cuff weakness; and lumbar spine multilevel disc herniations with radiating pain to the right leg. Treatment to date has included medications, diagnostics, injection, and physical therapy. Medications have included Ibuprofen and Terocin lotion. A progress note from the treating physician, dated 03/19/2015, documented a follow-up visit with the injured worker. Currently, the injured worker complains of constant burning pain in her right lower extremity; stiffness and spasm of the cervical spine with radiation to the upper extremities, especially on the right side; stiffness and spasm of the lumbar spine; she has had 5 or 6 sessions of physical therapy just after her injury that did not help; and she did not see improvement with this therapy which was more modality driven, and not very exercise-based. Objective findings included spasm of the cervical spine; positive impingement in the right shoulder; stiffness and spasm of the lumbar spine with positive straight leg raise and radicular pain into the right lower extremity; and needs more active physical therapy. The treatment plan has included the request for physical therapy 2 times a week for 6 weeks for the lumbar spine.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy 2 times a week for 6 weeks for the lumbar spine:** Upheld

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

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

**Decision rationale:** Physical Therapy 2 times a week for 6 weeks for the lumbar spine is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The MTUS recommends up to 10 visits for this condition. The documentation indicates that the patient has had prior physical therapy but there is no evidence that this prior PT has provided functional improvement. Additionally, the MTUS recommends up to 10 visits for this condition and the request exceeds this number. The request for physical therapy is not medically necessary.