

<b>Case Number:</b>	CM15-0111597		
<b>Date Assigned:</b>	06/18/2015	<b>Date of Injury:</b>	11/12/2014
<b>Decision Date:</b>	07/17/2015	<b>UR Denial Date:</b>	05/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/09/2015

### 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 67 year old male, who sustained an industrial injury on 11/12/2014. Diagnoses include cervical myospasm, cervical pain, cervical radiculopathy, rule out cervical disc protrusion, lumbar myospasm, lumbar radiculopathy, lumbar sprain/strain, and rule out lumbar disc protrusion. Treatment to date has included 21 visits of physical therapy and modified work. Per the Primary Treating Physician's Progress Report dated 5/18/2015, the injured worker reported frequent moderate to 7/10 neck pain with radiation to the bilateral upper extremities with numbness, frequent moderate to 7/10 upper/mid back pain and stiffness, and frequent moderate to 8/10 stabbing low back pain and stiffness. Physical examination revealed decreased and painful ranges of motion of the cervical and thoracic spine. There was tenderness to palpation and spasm of the cervical and thoracic paravertebral muscles. He had a slow and guarded gait and there was tenderness to palpation of the bilateral sacroiliac joints and lumbar paravertebral muscles. The plan of care included, and authorization was requested for acupuncture (2x3), surgical consultation, physical therapy (1x4) and range of motion test.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy 1 time a week for 4 weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy, pages 98-99.

**Decision rationale:** Physical 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. However, there is no clear measurable evidence of progress with the PT treatment already rendered including milestones of increased ROM, strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints, clinical findings, and functional status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. The Chronic Pain Guidelines allow for visits of physical therapy with fading of treatment to an independent self-directed home program. It appears the employee has received significant therapy sessions without demonstrated evidence of functional improvement to allow for additional therapy treatments. There is no report of acute flare-up, new injuries, or change in symptom or clinical findings to support for formal PT in a patient that has been instructed on a home exercise program for this chronic injury. Submitted reports have not adequately demonstrated the indication to support further physical therapy when prior treatment rendered has not resulted in any functional benefit. The Physical therapy 1 time a week for 4 weeks is not medically necessary and appropriate.

**Range of motion testing:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), low back.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Chapter 7, Independent Medical Examinations and Consultations, pages 137-138.

**Decision rationale:** Computerized ROM testing is not supported by MTUS, ODG, or AMA Guides. Evaluation of range of motion and motor strength are elementary components of any physical examination for musculoskeletal complaints and does not require computerized equipment. In addition, per ODG, for example, the relation between range of motion measurements and functional ability is weak or even nonexistent with the value of such tests like the sit-and-reach test as an indicator of previous spine discomfort is questionable. They specifically noted computerized measurements to be of unclear therapeutic value. Medical necessity for computerized strength and ROM outside recommendations from the Guidelines has not been established. The Range of motion testing is not medically necessary and appropriate.