

<b>Case Number:</b>	CM15-0118144		
<b>Date Assigned:</b>	06/26/2015	<b>Date of Injury:</b>	12/07/2004
<b>Decision Date:</b>	07/27/2015	<b>UR Denial Date:</b>	05/18/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/18/2015

### 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:

This 55 year old female sustained an industrial injury on 12/07/04. She subsequently reported back, neck and left upper extremity pain. Diagnoses include chronic neck pain. Treatments to date include MRI testing, physical therapy and prescription pain medications. The injured worker continues to experience low back pain with radiation to the left lower extremity, left foot numbness. Upon examination, there was tenderness over the right side of the cervical paraspinal musculature that extends down to the right levator scapula and right trapezius muscle. Straight leg raise was negative bilaterally. A request for Physical therapy QTY: 8 was made by the treating physician.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy QTY: 8: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines physical medicine guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), neck and upper back (acute and chronic).

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

**Decision rationale:** Submitted reports have no acute flare-up or specific physical limitations to support for physical therapy. 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. There is unchanged chronic symptom complaints, clinical findings, and work 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 9-10 visits of physical therapy with fading of treatment to an independent self-directed home program. The patient is without physiologic evidence of tissue insult, neurological compromise, or red-flag findings to support treatment request. Submitted reports have not adequately demonstrated the support of further physical therapy without noted acute new injuries or change in clinical presentation for this chronic injury of 2004. The Physical therapy QTY: 8 is not medically necessary and appropriate.