

<b>Case Number:</b>	CM15-0079000		
<b>Date Assigned:</b>	04/30/2015	<b>Date of Injury:</b>	12/08/2014
<b>Decision Date:</b>	06/05/2015	<b>UR Denial Date:</b>	04/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/24/2015

### 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 44 year old female who sustained an industrial injury on 12/8/14. The injured worker was diagnosed as having cervical myospasms, cervical radiculopathy, cervical sprain/strain, lumbar myospasms, lumbar sprain/strain, right shoulder impingement syndrome, right shoulder pain and right shoulder sprain/strain. Currently, the injured worker was with complaints of discomfort in the cervical spine, lumbar spine and right shoulder. Previous treatments included medication management, therapy, and activity modification. Previous diagnostic studies included radiographic studies and magnetic resonance imaging. The injured workers pain level was noted as 5/10 in the cervical spine, 6/10 in the lumbar spine and 6/10 in the right shoulder. Physical examination was notable for tenderness to palpation of cervical paravertebral muscles and lumbar paravertebral muscles, decreased range of motion in right shoulder as well as tenderness to palpation of the acromioclavicular joint. The plan of care was for physical therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**8 Physical Therapy (2 times a week for 4 weeks) for the Lumbar Spine, as an outpatient for submitted diagnosis of myospasms, sprain/strain, radiculopathy: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174-175.

**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 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 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 8 Physical Therapy (2 times a week for 4 weeks) for the Lumbar Spine, as an outpatient for submitted diagnosis of myospasms, sprain/strain, radiculopathy is not medically necessary and appropriate.