

<b>Case Number:</b>	CM17-0010365		
<b>Date Assigned:</b>	01/20/2017	<b>Date of Injury:</b>	11/08/2016
<b>Decision Date:</b>	02/14/2017	<b>UR Denial Date:</b>	01/05/2017
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/16/2017

### **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, Pain Management

### **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 51 year old male who sustained an industrial injury on 11-08-2016. The documentation on 11-23-2016 noted the injured worker has complaints of pain in the thoracic area with numbness along right arm and back pain from neck through thoracic to low back described as constant, sharp, stabbing and worsening at night. The pain radiates down both arms, dependent on which side he sleeps on. The physical exam reveals tenderness at the cervical, thoracic, and lumbar spine with decreased flexion, extension, and lateral bending. A review of the medical records shows the injured worker has diagnosis that include strain of muscle, fascia, and tendon of lower back, subsequent encounter; other muscle spasm; dorsalgia, unspecified; radiculopathy, cervical region (right arm). The treatment to date includes medications of Ibuprofen and Soma. The treatment plan on 11-23-2016 includes a referral to physical therapy. There is no documentation of attendance of physical therapy sessions. The worker is to start home exercise, use warm and cool compresses, and use medication as needed. He has activity restrictions including no heavy pushing or pulling, no pushing, lifting or pulling weight greater than 5 pounds, no prolonged walking or standing and a desk job is recommended. The original utilization review 01-05-2017 non-certified the request for Physical therapy three times a week for two weeks for the cervical, thoracic, and lumbar.

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

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

**Physical therapy three times a week for two weeks for the cervical, thoracic, and lumbar:**  
Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2016.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2016, Section(s): Physical medicine treatment. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back and neck Chapter, Physical Therapy.

**Decision rationale:** Regarding the request for physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, it does not appear the patient has undergone physical therapy previously. Guidelines recommend a 6-visit trial with further therapy recommended based upon documentation of objective functional improvement. As such, the current 6 therapy sessions is consistent with guideline recommendations. Therefore, the currently requested physical therapy is medically necessary.