

|                       |              |                              |            |
|-----------------------|--------------|------------------------------|------------|
| <b>Case Number:</b>   | CM13-0043668 |                              |            |
| <b>Date Assigned:</b> | 12/27/2013   | <b>Date of Injury:</b>       | 04/15/2013 |
| <b>Decision Date:</b> | 02/24/2014   | <b>UR Denial Date:</b>       | 10/17/2013 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 10/24/2013 |

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine Rehabilitation and is licensed to practice in Illinois. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 61 year old male who reported an injury on 04/15/2013. The patient is diagnosed with cervical strain and sprain, lumbosacral sprain and strain, and neuritis or radiculitis of the thoracic or lumbosacral spine. The patient was seen by [REDACTED] on 09/24/2013. The patient reported 4/10 neck pain and 5/10 right shoulder pain. The patient also reported continuous lower back pain. Physical examination revealed positive Milgram's testing. The treatment recommendations included physical therapy 3 times per week for 4 weeks.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy 2-3 x week x 6-8 weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

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

**Decision rationale:** The California Medical Treatment Utilization Schedule (MTUS) Guidelines state active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Guidelines allow for a fading of treatment frequency plus active self-

directed home physical medicine. As per the clinical documentation submitted, there is no physical examination indicating functional deficits that would support the need for skilled physical medicine treatment. The patient has been instructed in a home exercise program. The medical necessity for the requested service has not been established. As such, the request for Physical therapy 2-3 x week x 6-8 weeks is non-certified.