

<b>Case Number:</b>	CM13-0038566		
<b>Date Assigned:</b>	12/18/2013	<b>Date of Injury:</b>	11/03/2000
<b>Decision Date:</b>	04/01/2015	<b>UR Denial Date:</b>	10/17/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/25/2013

### 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: Massachusetts

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 reported on 11/3/2000. He has reported neck pain. The diagnoses were noted to have included cervical spondylosis, cervical myofascial sprain; and lumbar myofascial sprain with the judge of changes; muscles thousand; cervicalgia; chronic pain; and low back pain. Treatments to date have included consultations; diagnostic imaging studies; trigger point injections (4/2013); and medication management. The work status classification for this injured worker (IW) was noted to be permanent and stationary as per the report of 3/7/02, and with recommended permanent work restrictions. The only progress note provided for my review was dated 4/18/2013. The 10/10/2013 request for authorization for this Utilization Review was a formal letter from the physical therapy group, and not by request for authorization (RFA) form; and provided no history. The Permanent and Stationary Report was dated 3/7/2002, stating cervical and lumbar spine pain. On 10/17/2013, Utilization Review (UR) modified, for medical necessity, the request, made on 10/10/2013, for physical therapy 3 x a week x 4 weeks (12 sessions) for the neck and back - to 3 x a week x 2 weeks (6 sessions) for the neck and back. The American College of Occupational and Environmental Medicine Guidelines, physical therapy - spine; and the Official Disability Guidelines, physical therapy - Lumbar; and the Medical Treatment Utilization Schedule, post- surgical treatment guidelines, manual manipulation/physical therapy - low back, were cited. The rationale provided stated that no new or recent reports indicate the IW is having a recent exacerbation of symptoms that would warrant a course of skilled therapy.

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

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

**PHYSICAL THERAPY (PT) FOR THE NECK AND BACK, 3 X PER WEEK X 4 WEEKS:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: 1.) ACOEM guidelines; 2.) Postsurgical treatment guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (1) Chronic pain, Physical medicine treatment. (2) Preface, Physical Therapy Guidelines.

**Decision rationale:** The claimant is nearly 15 years status post work-related injury and continues to be treated for chronic back and neck pain. In terms of physical therapy treatment for chronic pain, guidelines recommend a six visit clinical trial with a formal reassessment prior to continuing therapy. In this case, the number of visits requested is in excess of that recommended and therefore not medically necessary.