

<b>Case Number:</b>	CM15-0138954		
<b>Date Assigned:</b>	07/29/2015	<b>Date of Injury:</b>	01/21/2015
<b>Decision Date:</b>	08/26/2015	<b>UR Denial Date:</b>	06/23/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/20/2015

### 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: New York

Certification(s)/Specialty: Internal Medicine

### 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 57 year old female, who sustained an industrial injury on 1/21/2015. Diagnoses include lumbosacral sprain/strain, and lower thoracic and upper lumbar sprain/strain. Treatment to date has included oral medications, Toradol injections and a spinal surgical consultation. Medications have included Mobic, Tylenol and Naprosyn. Per the Primary Treating Physician's Progress Report dated 5/06/2015, the injured worker reported continued headaches and difficulty with focusing as well as absentmindedness and forgetfulness. She hit her head on January 27, 2015 when a wall mirror fell and she fell backwards. Physical examination revealed intact strength in the EHL, tibialis anterior, gastrocs and quads. Straight leg raise was negative. Sensation was intact. Range of motion was mildly restricted. The plan of care included a neurological evaluation and physical therapy. Authorization was requested for 18 visits of physical therapy for the cervical spine.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy for the cervical spine, two to three times a week for six weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99; 127.

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

**Decision rationale:** According to the California MTUS Treatment guidelines, physical therapy (PT) is indicated for the treatment of musculoskeletal pain. 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. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Per ODG, patients should be formally assessed after a "6-visit trial" to see progress made by patient. When the duration and/or number of visits have exceeded the guidelines, exceptional factors should be documented. Additional treatment would be assessed based on functional improvement and appropriate goals for additional treatment. There is no specific indication for the requested initial 18 physical therapy sessions. The request exceeds MTUS and ODG guidelines. Medical necessity for the requested PT visits has not been established. The requested services are not medically necessary.