

<b>Case Number:</b>	CM15-0142938		
<b>Date Assigned:</b>	08/03/2015	<b>Date of Injury:</b>	07/21/2010
<b>Decision Date:</b>	09/01/2015	<b>UR Denial Date:</b>	06/25/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/23/2015

### 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, 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 70 year old male, who sustained an industrial injury on July 21, 2010. He reported left knee pain. Treatment to date has included medication, heat and cold therapy, physical therapy, home exercise program, electrical stimulation therapy, x-rays, chiropractic care, acupuncture and cortisone injections. Currently, the injured worker complains of pain located in his neck rated at 6-7 on 10, low back, both shoulders and both hands. He also reports left ankle weakness and pain described as sharp that is aggravated by walking and rated at 7 on 10. He reports a band of pain across his lower back and describes it as sharp with intermittent spasms in his calves bilaterally. He reports the pain is aggravated by lifting and moving objects, regardless of their weight. He is currently diagnosed with cervical strain with superimposed spondylosis, lumbosacral strain, degenerative disc disease (lumbar spine) and left ankle strain. His work status is permanent and stationary, with permanent restriction; however, he is retired. A progress note dated June 18, 2015, states the injured worker experiences a decrease in low back pain from medication (4 on 10). The note also states the injured worker experienced pain relief from heat and cold therapy. The injured worker reports physical therapy and modalities learned are beneficial, and has helped him to maintain improved function, range of motion, engage in activities of daily living and decrease his pain level, per note dated June 18, 2015. The following, physical therapy 2 times a week for 4 weeks for the cervical, lumbar and left ankle (to improve function and decrease pain), Naprosyn 55 mg #60 (to decrease inflammation and pain) and Tramadol 50 mg #60 (to provide improved pain relief) are requested.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy 2 times a week for 4 weeks for the cervical, lumbar, and left ankle:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98 and 99. Decision based on Non-MTUS Citation Official Disability Guidelines - Treatment for Workers' Compensation (ODG-TWC) Neck and Upper Back Procedure Summary Online Version last updated 05/12/2015; ODG-TWC Low Back Procedure Summary Online Version last updated 05/12/2015; ODG-TWC Ankle & Foot Procedure Summary Online Version last updated 03/26/2015.

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

**Decision rationale:** Regarding the request for additional 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, there is documentation of completion of prior PT sessions with indication of objective functional improvement, reduction in pain, and improved ability to perform activities of daily living with ongoing use of home exercise programs. Therefore, it is unclear what remaining deficits that cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised therapy. As such, the currently requested additional physical therapy is not medically necessary.

**Naprosyn 550mg #60:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-72.

**Decision rationale:** Regarding the request for Naproxen, Chronic Pain Medical Treatment Guidelines state that NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Within the documentation available for review, there is indication that Naproxen is providing analgesic benefits and objective functional improvement. Given this, the currently requested Naproxen is medically necessary.