

<b>Case Number:</b>	CM15-0089954		
<b>Date Assigned:</b>	05/14/2015	<b>Date of Injury:</b>	08/24/2012
<b>Decision Date:</b>	06/16/2015	<b>UR Denial Date:</b>	04/22/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/11/2015

### 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: 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 45 year old female with an industrial injury dated 08/24/2012. Her diagnosis was thoracic back strain/sprain. Prior treatments included physical therapy and surgery to shoulder and cervical spine. She presents on 03/11/2015 with complaints thoracic spine pain. Physical exam of the back revealed forward flexion to only touch the fingers to the knees secondary to pain in neck and left shoulder. There was decreased left lateral bending and left rotation secondary to pain. There were no sensory deficits of the lower extremities. Treatment plan included physical therapy for her thoracic back, ice and medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy 2x3 weeks for the thoracic:** Upheld

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

**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. (1) Chronic pain, Physical medicine treatment. (2) Preface, Physical Therapy Guidelines.

**Decision rationale:** The claimant sustained a work injury in August 2012 and continues to be treated for left shoulder and thoracic spine pain. She was seen for the purpose of a permanent and stationary evaluation on 02/27/15. She reported not having previously received therapy for her thoracic spine. A course of therapy was ordered. However, when seen by the primary treating provider in November 2014 she was receiving treatments for her thoracic spine which had not helped. As of 11/11/14 there are 17 treatment sessions documented. In this case, the claimant has already had therapy treatments and prior treatments. Compliance with a home exercise program would be expected and would not require continued skilled physical therapy oversight. Providing the number of requested additional skilled therapy services would not reflect a fading of treatment frequency and could promote dependence on therapy provided treatments. The request was made based on inaccurate information regarding the treatment already provided. Therefore the requested therapy is not medically necessary.