

<b>Case Number:</b>	CM14-0165472		
<b>Date Assigned:</b>	10/10/2014	<b>Date of Injury:</b>	03/27/1997
<b>Decision Date:</b>	11/12/2014	<b>UR Denial Date:</b>	09/29/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/08/2014

### 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. The expert 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 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/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 injured worker is a 69-year-old female who reported an injury of unspecified mechanism on 03/27/1997. On 09/11/2014, her diagnoses included lumbago, sprain/strain of the neck, sprain/strain of the thoracic region, and sprain/strain of the lumbar region. On 08/11/2014, it was noted that she had not been seen by the treating physician since 12/06/2012. She had 2 unidentified surgeries in 2013. Her complaints included neck pain with shooting pains to the shoulders and numbness in the upper back. Her medications included hydrocodone and oxycodone with no dosages noted. On 09/11/2014, it was reported that she had an adverse reaction to Zanaflex. She inquired about physical therapy. A prescription was written for 8 sessions of physical therapy for the thoracic spine. There was no rationale included in the injured worker's chart. A Request for Authorization dated 09/13/2014 was included.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Eight (8) Physical therapy sessions for upper back:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG)

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

**Decision rationale:** The California MTUS Guidelines recommend active therapy as indicated for restoring flexibility, strength, endurance, function, range of motion and to alleviate discomfort. Patients are expected to continue active therapies at home. There was no documentation of objective functional deficits or pain related to the injured worker's upper back. The recommended schedule for myalgia and myositis unspecified is 9 to 10 visits over 8 weeks. The requested 8 visits over 4 weeks exceed the recommendations in the guidelines. The need for physical therapy was not clearly demonstrated in the submitted documentation. Therefore, this request for eight (8) Physical therapy sessions for upper back is not medically necessary and appropriate.