

<b>Case Number:</b>	CM14-0218293		
<b>Date Assigned:</b>	01/08/2015	<b>Date of Injury:</b>	09/08/2014
<b>Decision Date:</b>	03/12/2015	<b>UR Denial Date:</b>	11/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/30/2014

### 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. 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

### 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 female, who was injured on September 8, 2014, while performing regular work duties. The injury is to the anterior chest wall, and due to a patient striking the injured worker directly on the sternum. On November 19, 2014, the injured worker was seen by [REDACTED], and demonstrated objective findings of pain with flexion, extension, and rotation. An x-ray of the right shoulder on November 24, 2014, is unremarkable. An x-ray of the chest on this date is also unremarkable. The injured worker received treatment which included modified work duty, no lifting, pushing, pulling over 15 pounds, medications, radiological imaging, and ice applications. The request for authorization is for eight (8) physical therapy, two (2) times weekly for four (4) weeks, for the anterior chest wall for submitted diagnosis of anterior chest contusion as an outpatient. The primary diagnosis is contusion of chest wall. On November 25, 2014, Utilization Review provided a modified certification of six (6), physical therapy, six (6) sessions, anterior chest wall for submitted diagnosis of anterior chest contusion as an outpatient, based on ODG guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**8 Physical Therapy 2 times a week for 4 weeks for Anterior Chest Wall: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines; Work Loss Data Institute, LLC; Corpus Christi, TX; www.odg-twc.com; Section; Low Back - Lumbar & Thoracic (Acute & Chronic).

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

**Decision rationale:** This patient presents with pain in the anterior chest from a contusion on 9/8/14. The current request is for 8 PHYSICAL THERAPY 2 TIMES PER WEEK FOR 4 WEEKS FOR ANTERIOR CHECK WALL. The utilization review modified the certification from the requested 8 sessions to 6 sessions, with the remaining 2 non-certified. The rationale for the partial certification was not provided in the medical files. For physical medicine, the MTUS Guidelines page 98 and 99 recommends for myalgia, myositis, and neuritis; type symptoms 9 to 10 sessions over 8 weeks. There is no indication that this patient has participated in any physical therapy. In this case, a course of 8 sessions to address the patient's complaints is within MTUS guidelines. This request IS medically necessary.