

<b>Case Number:</b>	CM15-0010844		
<b>Date Assigned:</b>	01/28/2015	<b>Date of Injury:</b>	11/17/2002
<b>Decision Date:</b>	03/18/2015	<b>UR Denial Date:</b>	01/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/20/2015

### 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: Maryland

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Neuromuscular 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 67- year old male, who sustained an industrial injury on November 17, 2002. He has reported a low back injury while trying to break up a fight between two teenagers. The diagnoses have included thoracic/lumbar neuralgia, neuritis, radiculitis, myalgia and myositis. Treatment to date has included pain medication, physical therapy, activity limitations, ice/cold therapy, a gym membership and routine follow up. Currently, the IW complains of lumbar spine pain that radiated to the left thigh and foot. Pain was characterized as chronic, aching, stabbing and throbbing. Pain was rated an eight at the worst and three at the best. Pain was reported aggravated by stooping, bending, squatting, twisting, turning, lifting and carrying ten pounds, cold weather, sitting greater than 30 minutes and standing greater than ten minutes. On January 16, 2015, the Utilization Review decision non-certified a request for eight physical therapy visits to the right shoulder, noting the worker had received previous physical therapy and there was no documentation in the record submitted that revealed any functional improvement other than improvement with water therapy. The MTUS, Chronic Pain Medical Treatment Guidelines was cited. On January 20, 2015, the injured worker submitted an application for IMR for review of eight physical therapy visits to the right shoulder.

### 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: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Functional Improvement Measures, Physical Medicine Page(s): (s) 48.

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

**Decision rationale:** Physical Therapy 2 times a week for 4 weeks is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines recommend up to 10 visits for this condition. The documentation does not indicate functional improvement from prior physical therapy. The patient should be versed in a home exercise program as his injury was in 2002. The documentation indicate recent approval for a gym membership. The request for an additional 8 weeks of physical therapy is not medically necessary.