

<b>Case Number:</b>	CM15-0073714		
<b>Date Assigned:</b>	04/23/2015	<b>Date of Injury:</b>	11/21/2013
<b>Decision Date:</b>	05/21/2015	<b>UR Denial Date:</b>	03/25/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/17/2015

### 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, Indiana, New York  
Certification(s)/Specialty: Internal 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 50 year old male, who sustained an industrial injury on 11/21/2013. On provider visit dated 03/17/2015 the injured worker has reported back, neck and leg pain. On examination of the neck, range of motion was decreased, diffuse tenderness to both shoulders and shoulder mobility was limited. The diagnoses have included bilateral shoulder strain. Treatment to date has included medication, diagnostic studies and physical therapy. The provider requested physical Therapy 2 x per week x 3 weeks for the thoracic.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy 2 x per week x 3 weeks for the throacic:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Section, Physical Therapy.

**Decision rationale:** Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, physical therapy two times per week times three weeks to the thoracic spine is not medically necessary. Patients should be formally assessed after a six visit clinical trial to see if the patient is moving in a positive direction, no direction or negative direction (prior to continuing with physical therapy). When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted. In this case, the injured worker's working diagnoses are lumbosacral strain with multilevel degenerative disc; L5-S1 disc herniation with sciatica; status post cervical surgery. Documentation from a November 25, 2014 progress note states the injured worker completed physical therapy and acupuncture that were not helpful. The location for acupuncture treatment and physical therapy are not provided in that progress. The utilization review indicates the injured worker received a clinical trial of six physical therapy visits. This most recent progress note in the medical record, dated January 27, 2015, does not document any additional physical therapy or conservative treatment. There is no clinical indication or rationale in the medical record concerning additional physical therapy. There is no documentation evidencing objective functional improvement with the initial six physical therapy visits. There are no compelling clinical facts in the medical record indicating additional physical therapy is clinically warranted. Consequently, absent clinical documentation with objective functional improvement (from prior physical therapy) and compelling clinical documentation indicating additional physical therapy is warranted, physical therapy two times per week times three weeks to the thoracic spine is not medically necessary.