

Case Number:	CM13-0027433		
Date Assigned:	11/22/2013	Date of Injury:	05/25/2000
Decision Date:	08/19/2014	UR Denial Date:	08/20/2013
Priority:	Standard	Application Received:	09/20/2013

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 48-year-old female who reported an injury on 05/25/2000. The mechanism of injury was noted to be a motor vehicle accident. Her prior treatments were noted to be NSAIDS, opioids, muscle relaxants, antidepressants, antiepileptics, surgery, nerve blocks, steroid injections, physical therapy, and psychological management. Her diagnosis was noted to be pain in joint of shoulder region; cervical spondylosis without myelopathy; cervical brachial syndrome; brachial neuritis/radiculitis; and thoracic sprain and strain. The injured worker's most recent clinical evaluation submitted is dated 08/08/2013. The injured worker presents for a follow-up of her right shoulder. She reported therapy was helping. The physical examination notes positive impingement signs but negative Jobe's. The treatment plan indicates further therapy will resolve this recent flare-up and a follow-up appointment in 6 weeks. The provider's rationale for the request was provided within the documentation dated 08/08/2013. A request for authorization for medical treatment was not provided within this documentation.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY FOR THE CERVICAL AND THORACIC SPINE, THREE (3) TIMES A WEEK FOR SIX (6) WEEKS: Upheld

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

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

Decision rationale: The request for physical therapy for the cervical and thoracic spine 3 times a week for 6 weeks is not medically necessary and appropriate. The California MTUS Chronic Pain Medical Treatment Guidelines recommend physical medicine. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. The physical medicine guidelines allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active, self-directed home physical medicine. The guidelines allow 8-10 visits over 4 weeks. The clinical information provided within this review fails to provide the injured worker's objective functional deficits. There is no documentation of range of motion values or motor strength scores. The information provided indicates previous physical therapy; however, it is not noted how many visits have been used. In addition, the request for physical therapy 3 times a week for 6 weeks is in excess of the recommendations according to the guidelines. Therefore, the request for physical therapy for the cervical and thoracic spine 3 times a week for 6 weeks is not medically necessary.