

Case Number:	CM13-0039926		
Date Assigned:	12/20/2013	Date of Injury:	09/12/2004
Decision Date:	11/24/2014	UR Denial Date:	10/04/2013
Priority:	Standard	Application Received:	10/28/2013

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 Family Medicine and is licensed to practice in California. 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:

This is a 61 year old female patient who sustained a work related injury on 9/12/2004. The exact mechanism of injury was not specified in the records provided. The current diagnoses include lumbar radiculopathy, lumbar facet arthropathy, cervical radiculopathy and diabetes. Per the doctor's note dated 1/15/14, patient has complaints of low back pain that radiates to the left lower extremity to the level of foot and toes, with tingling and numbness in the lower extremity, low back pain spasm worsen on laying down neck pain that radiates to the left upper extremity at 6-8/10 with medications and 8/10 without medications. Physical examination revealed range of motion of the lumbar spine revealed moderate reduction secondary to pain, spinal vertebral tenderness in the lumbar spine at the L4-S1 level, lumbar myofascial tenderness and paraspinal muscle spasm on palpation. The current medication lists include Naprosyn, Neurontin, Tramadol, Norco, Metformin, Glimepiride and Vicodin. The patient has had MRI of the lumbar spine that was done May 12, 2012 that revealed L4-5 first degree spondylolisthesis on a degenerative facet arthropathy; X-ray of the cervical and lumbar spine that revealed disc narrowing. The patient has had a left L4-5 transforaminal epidural steroid injection on December 1, 2011 and cervical transforaminal epidural steroid injection on 9/24/10. She has had a urine drug toxicology report on 4/9/13. The patient has received an unspecified number of PT visits for this injury. The patient has used a TENS unit. She was certified for lumbar PT, acupuncture and several lumbar ESIs in 2006.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy Cervical: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Chronic Pain Medical Treatment Guidelines, and pages 98-99

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy (PT) Page(s): 98.

Decision rationale: The guidelines cited below state, " allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home physical medicine". A recent detailed clinical evaluation note of treating physician was not specified in the records. The recent detailed examination of the cervical region was not specified in the records provided. Any significant functional deficits of the cervical region that would require additional PT visits was not specified in the records provided. Patient has received an unspecified number of PT visits for this injury. Previous conservative therapy notes were not specified in the records provided. The requested additional visits in addition to the previously certified PT sessions are more than recommended by the cited criteria. The records submitted contain no accompanying current PT evaluation for this patient. There was no evidence of ongoing significant progressive functional improvement from the previous PT visits that is documented in the records provided. Previous PT visits notes were not specified in the records provided. Per the guidelines cited, "Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels." A valid rationale as to why remaining rehabilitation cannot be accomplished in the context of an independent exercise program is not specified in the records provided. The request for physical therapy cervical is not fully established for this patient.