

Case Number:	CM13-0040604		
Date Assigned:	12/20/2013	Date of Injury:	06/01/2012
Decision Date:	03/11/2014	UR Denial Date:	09/24/2013
Priority:	Standard	Application Received:	10/29/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Internal Medicine and is licensed to practice in New York 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 physician 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 claimant is a 29 year old male who sustained a work injury on 06/01/2012 when he was involved in a motor vehicle accident. His diagnoses include sprains/strains of the neck, shoulder, thoracic spine, and lumbar spine. On exam he walks with an antalgic gait and has full range of motion of the cervical spine, mild tenderness of the cervical spine and full range of motion of the upper and lower extremities. The neurologic exam is normal. He has been treated with medical therapy and physical therapy. The treating provider has requested additional physical therapy sessions for the cervical, thoracic, lumbar and bilateral shoulders.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy Two times a week for Three weeks for Cervical, Thoraic, Lumbar, and Bilateral Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints, Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment for Worker's Compensation, online edition, Neck & Upper Back, shoulder, Low Back-Lumbar & Thoraic.

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

Decision rationale: Per California MTUS Treatment Guidelines 2009, physical therapy is indicated for the treatment of chronic pain. Recommendations state that for most patients with more severe acute and subacute pain conditions 8 to 12 visits over a period of over 6 to 8 weeks is indicated as long as functional improvement and program progression are documented. 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. 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. In this case the claimant has completed previous physical therapy sessions and there is no specific documentation indicating recent objective measurements of the claimant's functional deficits to be addressed by the requested additional physical therapy sessions. Medical necessity for the requested physical therapy sessions has not been established. The requested service is not medically necessary.