

Case Number:	CM13-0044012		
Date Assigned:	12/27/2013	Date of Injury:	02/28/2013
Decision Date:	02/25/2014	UR Denial Date:	10/15/2013
Priority:	Standard	Application Received:	10/31/2013

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 Orthopedic Surgery and Hand Surgery, and is licensed to practice in Texas. 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 patient was a 37 year old male with complaints of neck, mid back and low back pain resulting from a motor vehicle accident on 08/20/2013. The patient was seen on 09/12/2013 for his pain. The patient had pain documented as 20% neck pain, 80% arm pain, 80% back pain and 20% leg pain. The patient stated physical therapy and medication helped him with his pain. The patient had a positive straight leg raise and positive Spurling's test upon physical examination. The patient was recommended for MRI to establish pathology of his pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY (PT) Two (2) times a week for six (6) weeks QTY:12: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines-TWC and Title 8, Industrial Relations, Division 1. Department of Industrial Relations, Chapter 4.5 Division of Workers' Compensation. Subchapter 1. Administrative Director-Administrative Rules

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

Decision rationale: The request for PHYSICAL THERAPY (PT) Two (2) times a week for six (6) weeks QTY: 12 is non-certified. Physical therapy is recommended for restoring flexibility,

strength, endurance, function, and range of motion by guidelines. The patient did not have documented objective findings of decreased range of motion, endurance or strength. Furthermore, the patient was noted to have participated in a physical therapy program. However, there were no objective findings as to the outcome of the sessions. It is additionally noted that guidelines recommend 10 sessions for radiculitis. Therefore, the request for 12 additional sessions exceeds guideline recommendations. There were no extenuating circumstances submitted for review to support the additional sessions. Given the information submitted for review the request for PHYSICAL THERAPY (PT) Two (2) times a week for six (6) weeks QTY: 12 is non-certified.