

Case Number:	CM14-0004088		
Date Assigned:	01/31/2014	Date of Injury:	02/01/2012
Decision Date:	11/21/2014	UR Denial Date:	12/18/2013
Priority:	Standard	Application Received:	01/09/2014

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 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:

The injured worker is a 58-year-old female who reported an injury on 02/01/2012. The mechanism of injury was not stated. It was noted that the injured worker noticed a cyst on the left wrist in 2011, and after continuing to work with pain and discomfort, the injured worker filed a claim on 02/01/2012. The current diagnoses include cervical discopathy, lumbar discopathy, and bilateral carpal tunnel/double crush. The only physician progress report submitted for this review is documented on 03/13/2012. The injured worker underwent surgery to the left wrist to remove the cyst in 2011. Postoperative treatment included physical therapy. The current medication regimen includes ibuprofen. The injured worker reported mid and lower back pain with radiation into the buttock region and weakness in the lower extremities. Physical examination revealed pain and discomfort in the mid to distal lumbar segments, guarding and restricted range of motion of the lumbar spine, and reproducible symptomatology in the L5 and S1 dermatomes. X-rays of the thoracic spine revealed normal findings. Treatment recommendations include a lumbar MRI, a cervical MRI, electrodiagnostic studies, a cervical epidural injection, and a home exercise program. There was no Request for Authorization form submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

8 ADDITIONAL PHYSICAL THERAPY FOR THE LUMBAR SPINE, TWICE A WEEK FOR 4 WEEKS, AS AN OUTPATIENT: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints.

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

Decision rationale: The California MTUS Guidelines state 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. Treatment for unspecified myalgia and myositis includes 9 to 10 visits over 8 weeks. Treatment for unspecified neuralgia, neuritis and radiculitis includes 8 to 10 visits over 4 weeks. As per the documentation submitted, there was no evidence of a significant functional limitation upon physical examination. The injured worker has been instructed in a home exercise program. The medical necessity for additional physical therapy for the lumbar spine has not been established. There was no documentation of a previous course of physical therapy with evidence of objective functional improvement. Based on the clinical information received, the request is not medically necessary and appropriate.