

Case Number:	CM14-0004410		
Date Assigned:	02/05/2014	Date of Injury:	06/21/2013
Decision Date:	06/20/2014	UR Denial Date:	12/16/2013
Priority:	Standard	Application Received:	01/13/2014

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 Orthopedic Surgery 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 claimant is a 62-year-old female who was injured on June 21, 2013. Diagnoses included thoracic spine strain, lumbar spine strain, right lumbar radiculopathy, left rotator cuff tendinitis and impingement syndrome, and history of probable right great toe fracture. A progress note, dated January 9, 2014, indicates the claimant presents with complaints of low back pain flareups related to increased activity. The clinician does not indicate if any improvement was gained following the most recent 12 physical therapy sessions. The exam documents tenderness palpation about the thoracic spine with limited thoracic range of motion. Lumbar range of motion is diminished, there's tenderness palpation in the paraspinal musculature, and palpable muscle spasm. Straight leg raise test is negative. The neurologic exam documents patchy decreased sensation in the right lower extremity and left upper extremity. The diminished sensation is noted to be in an L5 distribution in the right lower extremity. In reviewing the previous progress notes as well therapy was requested multiple times including on August 30, 2013. The November 14, 2013 note indicates that the claimant has continuous therapy and shown "some improvement." The clinician recommends further therapy. The review in question was rendered on December 16, 2013. The reviewer noncertified request for physical therapy of the thoracic and lumbar spine noting that there was "some improvement" with our physical therapy. However, the reviewer indicates the claimant did not make significant gains in therapy that would support the request for continued supervised sessions. The claimant is documented as having completed 12 physical therapy visits previously.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY FOR THE THORACIC AND LUMBAR: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM GUIDELINES, CHAPTER 12- LOW BACK COMPLAINTS,

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES PHYSICAL MEDICINE, , 98-99

Decision rationale: The Chronic Pain Medical Treatment Guidelines supports the use of physical therapy in the management of chronic pain. Recommends up to 10 visits for myositis, radiculitis, and neuritis. Based on clinical documentation provided, the claimant already completed at least 12 physical therapy sessions, and potentially 18, but the documentation is unclear as to how many have actually been completed. The clinician fails to identify any objective functional improvement following the sessions. The 12 physical therapy visits already exceeds the recommendations of the guidelines. As such, secondary to lack of documented objective functional improvement and in accordance with the Chronic Pain Medical Treatment Guidelines, the request is not medically necessary.