

Case Number:	CM14-0011510		
Date Assigned:	02/21/2014	Date of Injury:	04/09/2013
Decision Date:	12/31/2014	UR Denial Date:	01/17/2014
Priority:	Standard	Application Received:	01/28/2014

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 Emergency 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:

The patient has a reported date of injury on 4/9/2013. The mechanism of injury is from lifting/carrying injury. The patient has a diagnosis of cervical spine herniated nucleus pulposus at C5-6 and C6-7 with stenosis, bilateral upper extremity radicular pain and paresthesia, lumbar spine herniated nucleus pulposus at L1-S1, bilateral lower extremity radicular pain and bilateral knee sprain. The medical reports were reviewed. The patient complains of neck pain with numbness and tingling to bilateral hands. Pain is 8/10. Pain to low back is also 8/10. Objective exam reveals cervical spine tenderness with decreased range of motion. Spurning's and shoulder decompression test are positive bilaterally. Lumbar exam has tenderness and decreased range of motion, positive straight leg raise. Paresthesia noted to bilateral upper and lower extremities (no details noted). Bilateral biceps, wrist extensors, triceps, extensor hallucis longus, tibialis anterior, gastrocnemius and peroneus groups with 4/5 weakness. Additional physical therapy was requested but no rationale or justification was documented. Physical therapy notes show 10 physical therapy sessions up to 1/24/14. No imaging or electrodiagnostic reports were provided for review. Medications include Ibuprofen, Flexeril and topical creams. The patient has had 5 prior physical therapy sessions authorized and had ongoing physical therapy sessions during time of request. Independent Medical Review is for 8 sessions of physical therapy. Prior UR on 1/17/14 recommended non-certification.

IMR ISSUES, DECISIONS AND RATIONALES

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

8 Sessions of Physical Therapy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines - Treatment in Worker's Compensation, Physical Therapy Guidelines

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

Decision rationale: As per the MTUS Chronic Pain Medical Treatment Guidelines, physical therapy is recommended for many situations with evidence showing improvement in function and pain. The patient has documented 5-10 physical therapy sessions that was approved and/or ongoing. The provider has failed to document any improvement from prior sessions or rationale as to why additional physical therapy sessions are necessary and why home directed therapy and exercise cannot be done. Therefore, this request for additional physical therapy is not medically necessary.