

Case Number:	CM14-0125087		
Date Assigned:	08/11/2014	Date of Injury:	03/25/2013
Decision Date:	09/16/2014	UR Denial Date:	07/28/2014
Priority:	Standard	Application Received:	08/07/2014

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 Illinois. 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 69-year-old female who reported an injury on 03/25/2013. The mechanism of injury was not provided with the review. Her diagnosis was noted to be left carpal tunnel syndrome. Prior treatments were noted to be physical therapy, occupational therapy, hand therapy and medications. The injured worker had a nerve conduction study performed as well as an electrodiagnostic study. A clinical evaluation listed the subjective complaints of back pain and right wrist pain as well as right hand pain. The injured worker reported that physical therapy helped decrease the warmth and cold sensations that she had been experiencing down her right leg to the bottom of the foot. She also indicated physical therapy helped decrease her low back pain. The objective findings indicated no tenderness along the central lumbar spine or paravertebral musculature bilaterally. There was no tenderness in the sacroiliac joint areas. There was full range of motion to the back and flexion of fingertips to the floor, extension of 30 degrees, lateral flexion of 45 degrees bilaterally, and lateral rotation of 30 degrees bilaterally. Straight leg raise test was negative and there was no tenderness of the low back. The treatment plan included continuing physical therapy and follow-up visits.

IMR ISSUES, DECISIONS AND RATIONALES

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

6 Sessions of physical therapy: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine.

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

Decision rationale: The request for 6 sessions of physical therapy is not medically necessary. The California MTUS Chronic Pain Medical Treatment Guidelines recommend physical medicine. 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. Active therapy requires an internal effort by the individual to complete a specific exercise or task. 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. The guidelines allow for fading of treatment frequency (from up to three visits per week to one or less) plus active self-directed home physical medicine. The guidelines provide 8 to 10 visits over 4 weeks. The injured worker had 6 sessions documented. The request for an additional six is in excess of the guidelines 8 to 10 visits. In addition, the injured worker fails to have significant objective functional deficits. As such, the request for 6 sessions of physical therapy is not medically necessary.

Neurologist consult/evaluation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 288, 305.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Office Visits.

Decision rationale: The request for neurologist consult/evaluation is not medically necessary. The Official Disability Guidelines recommend office visits as determined to be medically necessary. The need for a clinical office visit with a healthcare provider is individualized based upon a review of the patient's concerns, signs, and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medications such as opiates, or medicines such as certain antibiotics, require close monitoring. The medical necessity has not been objectively identified in the clinical notes. Therefore, a request for neurologist consult/evaluation is not medically necessary.