

Case Number:	CM14-0151016		
Date Assigned:	09/19/2014	Date of Injury:	03/06/2014
Decision Date:	11/12/2014	UR Denial Date:	08/27/2014
Priority:	Standard	Application Received:	09/16/2014

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 and Rehabilitation, has a subspecialty in Pain Medicine 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 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 65-year-old male who reported an injury on 03/06/2014. The mechanism of injury reported was when pallets fell on his back. The diagnoses included bilateral lumbar radiculopathy, L3-5 stenosis, lumbar spondylosis, cervical sprain, thoracic strain, right shoulder impingement syndrome. The previous treatments included medication. Within the clinical note dated 07/15/2014 it was reported the injured worker complained of constant right shoulder pain, decreases with raising of the left shoulder level or lifting items over 10 pounds. The injured worker rated his pain 5/10 in severity. Upon the physical examination, the provider noted the injured worker had tenderness to palpation and spasms of the superior scapular border, and over the mid scapular region. The provider noted mild palpable tenderness over the right acromioclavicular joint. The provider noted the injured worker to have tenderness to palpation of the lumbar paracervical muscles. The request submitted is for physiotherapy of the cervical, thoracic, and lumbar spine. However, the rationale is not submitted for clinical review. The Request for Authorization is not submitted for clinical review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physiotherapy two times a week for four weeks for the cervical, thoracic, lumbar spine:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines. Decision based on Non-MTUS Citation Official Disability

Guidelines, Low Back - Lumbar & Thoracic (Acute & Chronic) (updated 08/22/2014); Physical therapy (PT), Physical Therapy Guidelines

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

Decision rationale: The request for physiotherapy two times a week for four weeks for cervical, thoracic, lumbar spine is not medically necessary. The California MTUS Guidelines state that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion. The guidelines allow for fading of treatment frequency plus self-active directed home physical medicine. There is lack of documentation indicating the efficacy of the medication as evidenced by significant functional improvement. The number of sessions the injured worker has previously undergone was not submitted for clinical review. Therefore, the request is not medically necessary.