

Case Number:	CM14-0158234		
Date Assigned:	10/01/2014	Date of Injury:	02/24/2009
Decision Date:	11/14/2014	UR Denial Date:	08/25/2014
Priority:	Standard	Application Received:	09/26/2014

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 injured worker is a 39 year-old female, who sustained an injury on February 24, 2009. The mechanism of injury occurred when she fell on a wet floor. Diagnostics have included: 2009 cervical MRI - results not noted; EMG/NCS dated March 31, 2014, reported as showing moderate bilateral carpal tunnel syndrome. Treatments have included: medications, physical therapy, chiropractic, acupuncture. The current diagnoses are: cervical strain/sprain with radiculopathy, thoracic strain/sprain, lumbar strain/sprain with radiculopathy. The stated purpose of the request for Physical therapy 2 times per week for 4 weeks was not noted. The request for Physical therapy 2 times per week for 4 weeks was denied on August 25, 2014, citing a lack of documentation of an acute flare-up or exacerbation and is working full duty with minimal reported pain. Per the report dated July 30, 2014, the treating physician noted complaints of neck pain with radiation to the head, back and upper extremities; mid and low back pain with radiation to both feet. Exam findings included cervical paraspinal muscle hypertonicity, decreased cervical range of motion, decreased sensation to right C6 distribution, normal muscle strength and reflexes, lumbar paraspinal muscle hypertonicity, decreased lumbar range of motion, positive right-sided straight leg raising test, decreased right L4 sensation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 2 times per week for 4 weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back, Acute and Chronic, Physical therapy

Decision rationale: American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), CHAPTER 8, Neck and Upper Back Complaints, Summary of Recommendations and Evidence, Page 181; and Official Disability Guidelines (ODG), Neck and Upper Back, Acute and Chronic, Physical therapy, recommend continued physical therapy with documented objective evidence of derived functional benefit. The injured worker has neck pain with radiation to the head, back and upper extremities; mid and low back pain with radiation to both feet. The treating physician has documented cervical paraspinal muscle hypertonicity, decreased cervical range of motion, decreased sensation to right C6 distribution, normal muscle strength and reflexes, lumbar paraspinal muscle hypertonicity, decreased lumbar range of motion, positive right-sided straight leg raising test, decreased right L4 sensation. The treating physician has not documented sufficient objective evidence of derived functional benefit from completed physical therapy sessions, nor the medical necessity for additional physical therapy to accomplish a transition to a dynamic home exercise program. The criteria noted above not having been met, Physical therapy 2 times per week for 4 weeks is not medically necessary.