

Case Number:	CM14-0168602		
Date Assigned:	10/16/2014	Date of Injury:	04/03/2013
Decision Date:	12/05/2014	UR Denial Date:	09/09/2014
Priority:	Standard	Application Received:	10/13/2014

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 Family 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:

This is a 57 year old female patient who sustained a work related injury on 4/3/13. Patient sustained the injury when four boxes fell from a high shelf striking the back and head and neck. The current diagnoses include head contusion, cervical and shoulder sprain. As per records provided the doctor's note dated 8/20/14, patient has complaints of nausea with forward bending and walking at night and imbalance and disequilibrium. Per the doctor's note dated 6/12/14 patient had complaints of neck pain that was radiating to left shoulder with headache. Physical examination of the neck and shoulder revealed no acute distress, guarded range of motion (ROM), tenderness on palpation and normal sensory and motor examination. The current medication lists include Hydrochlorothiazide, calcium and vitamins. The patient has had an MRI of the cervical spine on 7/5/13 that revealed mild degenerative disc disease at C5-C6 and C6-C7. Diagnostic imaging reports were not specified in the records provided. The patient's surgical history includes tonsillectomy, rhinoplasty and cesarean section. She underwent ENG/VAT on 1/22/14 that revealed right vestibular weakness and nystagmus. Any operative/ or procedure note was not specified in the records provided. The patient has received 6 physical therapy (PT) visits for this injury.

IMR ISSUES, DECISIONS AND RATIONALES

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

4 additional physical therapy sessions for the head: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Work Loss Data Institute, LLC; Corpus Christi, TX

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter: Head (updated 11/17/14)

Decision rationale: MTUS guideline does not specifically address this issue, hence ODG was used. Per the ODG guidelines cited below, "... Vestibular rehabilitation should be considered in the management of individuals post concussion with dizziness and gait and balance dysfunction that do not resolve with rest..." Patient has had 6 sessions of vestibular therapy for this injury. A recent detailed clinical evaluation note of treating physician was not specified in the records. Per the doctor's note dated 6/12/14 physical examination of the neck and shoulder revealed no acute distress, and normal sensory and motor examination. The requested additional visits in addition to the previously rendered PT sessions are more than recommended by the cited criteria. There was no evidence of ongoing significant progressive functional improvement from the previous PT visits that was documented in the records provided. Previous rehabilitation visit notes documenting significant progressive functional improvement were not specified in the records provided. As per cited guidelines, when treatment duration or the number of visits exceeds the guideline, exceptional factors should be noted. As per the ODG "Home programs should be initiated with the first therapy session and must include ongoing assessments of compliance as well as upgrades to the program... Use of self-directed home therapy will facilitate the fading of treatment frequency, from several visits per week at the initiation of therapy to much less towards the end." Furthermore, documentation of response to other conservative measures such as oral pharmacotherapy in conjunction with rehabilitation efforts was not provided in the medical records submitted. A valid rationale as to why remaining rehabilitation cannot be accomplished in the context of an independent exercise program is not specified in the records provided. The medical necessity of the request for 4 additional physical therapy sessions for the head is not fully established in this patient.