

Case Number:	CM14-0031405		
Date Assigned:	06/20/2014	Date of Injury:	10/22/2013
Decision Date:	08/12/2014	UR Denial Date:	02/28/2014
Priority:	Standard	Application Received:	03/12/2014

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 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 54-year-old female who reported an injury on 10/22/2013, due to a fall. On 02/07/2014 the injured worker presented with lumbar spine pain. Prior therapy included modified duty, physical therapy visits, and medications. The diagnoses were pain in the back, sprain/strain of the right shoulder, muscle spasm in the back, sprain/strain of the thoracic, fall OT trip stumble, and pain in the joint right shoulder. On examination the injured worker's pain scale was an 8/10. The injured worker's right grip strength was significantly weaker than the left. The provider recommended physical therapy 3 times a week for 2 weeks to the lumbar spine, thoracic spine, and right shoulder. The provider's rationale was not provided. The Request for Authorization form was not included in the medical documents for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy 3 times a week for 2 weeks to the lumbar spine, thoracic spine, and right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98.

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

Decision rationale: The request for physical therapy 3 times a week for 2 weeks to the lumbar spine, thoracic spine, and right shoulder is not medically necessary. The California MTUS states 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, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. Injured workers are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. The guidelines allow for up to 10 visits of physical therapy for up to 4 weeks. There is lack of documentation indicating the injured worker's prior course of physical therapy, as well as the efficacy of the prior therapy. Additionally, injured workers are instructed and expected to continue active therapies at home as an extension of the treatment process and there are no significant barriers to transitioning the injured worker to an independent home exercise program. As such, the request is not medically necessary.