

Case Number:	CM14-0032381		
Date Assigned:	06/20/2014	Date of Injury:	08/20/2007
Decision Date:	07/18/2014	UR Denial Date:	02/17/2014
Priority:	Standard	Application Received:	03/14/2014

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 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 51 year old female who reported an injury on 08/20/2007. The mechanism of injury was not provided. The injured worker has an exam on 02/02/2014 due to complaints of neck pain on scale of 7/10 to bilateral upper extremities with sharp pain. She also complained of low back pain radiating to bilateral leg and knee with sharp pain. The exam revealed positive cervical compression on the right, positive jackson's, positive romberg's, positive neers sign, positive Hawkins sign, positive tinnell's sign at right elbow and wrist, positive braggards, positive patrick's fabere and decreased sensation. The diagnoses were cervical displacement without myelopathy, right upper extremity radiculopathy C5-C6, status post arthroscopic right repair, thoracic strain and lumbar strain. The treatment plan was to request physical therapy twice a week for four weeks. The request for medical necessity authorization was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY 2X4 CERVICAL, THORACIC, LUMBAR AND BILATERAL SHOULDERS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines Page(s): 99.

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

Decision rationale: The request for physical therapy twice a week for four weeks is non-certified. The California MTUS Guidelines recommend that passive therapy can provide short term relief during the early phases of pain treatment. The guidelines also recommend active therapy patients are instructed and expected to continue active therapies at home to maintain improvement levels. There was no evidence of any previous physical therapy, or of any recommended home exercises. There was a lack of documentation regarding medications and effectiveness. There was no evidence of functional deficits. Therefore the request for physical therapy is not medically necessary.