MAXIMUS Federal Services

Case Number:	CM14-0037549		
Date Assigned:	06/27/2014	Date of Injury:	10/23/2012
Decision Date:	08/26/2014	UR Denial Date:	03/14/2014
Priority:	Standard	Application Received:	03/28/2014

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 Occupational 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 applicant is a represented [redacted] employee who has filed a claim for chronic neck, bilateral shoulder, and bilateral wrist pain reportedly associated with an industrial injury of October 23, 2012.Thus far, the applicant has been treated with the following: Analgesic medications; attorney representation; transfer of care to and from various providers in various specialties; unspecified amounts of physical therapy over the course of the claim; and earlier cervical disk replacement surgery at C5-C6 on June 19, 2012.In a Utilization Review Report dated March 17, 2014, the claims administrator partially certified a request for 12 sessions of physical therapy as three (3) sessions of physical therapy.The applicant's attorney subsequently appealed.In a handwritten progress note dated February 27, 2014, it was stated that the applicant was not working and off of work, on total temporary disability. The note was very difficult to follow; however, it appeared that the attending provider was endorsing the applicant's remaining off of work, going to some nonindustrial complications which are not elaborated upon. The applicant had ongoing complaints of neck and low back pain, it was posited. Further physical therapy was endorsed.Earlier handwritten progress notes seemingly dated January 23, 2014 and February 25, 2014 were equally difficult to follow, not entirely legible, notable for comments that the additional physical therapy was being pursued for ongoing complaints of neck and low back pain at those points in time. It appeared that the applicant was working on those dates.

IMR ISSUES, DECISIONS AND RATIONALES

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

Continued Physical Therapy 3X per week X4 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck & Upper Back (updated 3/07/14), Physical Therapy (PT).

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

Decision rationale: The 12-session course of physical therapy proposed, in and of itself, represents treatment well in excess of the 8- to 10-session course recommended on page 99 of the MTUS Chronic Pain Medical Treatment Guidelines for radiculitis, the diagnosis reportedly present here. No rationale for treatment in excess of the MTUS parameters was proffered. It is further noted that the both pages 98 and 99 of the MTUS Chronic Pain Medical Treatment Guidelines emphasize active therapy, active modalities, tapering or fading the frequency of treatment over time and self-directed home physical medicine. The request, as written, thus, runs counter to MTUS parameters and principles. The attending provider's documentation was sparse, handwritten, at times illegible, and did not make a compelling case for a variance from the guidelines. Therefore, the request is not medically necessary.