

Case Number:	CM14-0040659		
Date Assigned:	06/30/2014	Date of Injury:	10/31/2011
Decision Date:	08/22/2014	UR Denial Date:	03/13/2014
Priority:	Standard	Application Received:	04/07/2014

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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Texas. 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 developed multiple complaints as a result of a fall from a chair on 10/31/11. On the date of injury her chair broke she subsequently developed low back pain, left knee, and right wrist pain. Per the submitted clinical records the injured worker underwent multiple rounds of physical therapy. Per AME she was reported she reported that physical therapy was ineffective. She had therapy for the low back, right wrist, and left knee without any substantive benefit. Most recent physical examinations documented myofascial pain. There was no documented evidence of active myospasm. Utilization review determination dated 03/13/14 non-certified as medically necessary the requests for physical therapy three times four to treat the thoracic, lumbar right upper extremity and left knee and cyclobenzaprine 7.5mg #60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 3 x 4 to treat the thoracic spine, lumbar spine, right upper extremity, and left knee: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Physical Therapy.

Decision rationale: The request for Physical therapy 3x4 to treat the thoracic spine, lumbar spine, right upper extremity, and left knee is not supported as medically necessary. Per the submitted clinical records the injured worker has undergone multiple courses of physical therapy over the three year history of this claim. It was reported in an AME that physical therapy was deemed ineffective. Given the provided historical information the medical necessity additional physical therapy would not be supported. The injured worker has long exceeded the maximum number of visits for her diagnosis.

Cyclobenzaprine 7.5mg #60, as prescribed: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-66.

Decision rationale: The request for Cyclobenzaprine 7.5mg #60 is not supported as medically necessary. Records indicate that the injured worker has chronic complaints of low back pain left knee and right wrist pain. Previous treatments have been ineffective. It is further noted, that California MTUS does not support the chronic use of this medication to treat pain. The most recent physical examinations do not establish the presence of active myospasm for which this medication may be medically necessary.