

Case Number:	CM14-0061091		
Date Assigned:	07/09/2014	Date of Injury:	12/07/2013
Decision Date:	09/18/2014	UR Denial Date:	04/02/2014
Priority:	Standard	Application Received:	05/02/2014

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 records indicate the injured worker is a 25 year old female injured on 12/07/13 due to being hit by an industrial vehicle. The most recent clinical note, dated 03/19/14, indicates the injured worker is with intermittent cervical pain described as burning and aggravated by lying down and radiating to the back, as well as intermittent moderate pain to the thoracic spine described as tingling and also pain to the lumbar spine described as severe, sharp pain that worsens when sitting and walking. The injured worker also complains of intermittent severe pain in the left shoulder. Examination on 3/19/14 has showed spasm and tenderness in the cervical, thoracic and lumbar paraspinals and upper shoulder muscles. Axial compression test was positive. Kemp's test and Yeoman test were positive. Distraction and depression tests were also positive. Supraspinatus and speed tests were also positive on the left. There is limitation in the range of motion of the left shoulder: abduction 138, flexion 121, ER 75, IR 85 degrees. Lumbar ROM (range of motion) was within the normal limits. The left biceps and brachioradialis tests were positive. Diagnoses include cervical disc herniation, lumbar displacement with myelopathy, thoracic sprain/strain, and bursitis/tendonitis of the left shoulder. It is noted that 11 PT (physical therapy) visits were previously approved. Prior utilization review denied request for physical therapy 3 times a week, times 4 weeks on 04/02/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy 3 x week x 4 weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines; Low Back.

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

Decision rationale: As per CA MTUS guidelines, physical medicine 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. The guidelines recommend 9 visits over 8 weeks intervertebral disc disorders without myelopathy (cervical / lumbar), 10 visits over 8 weeks for Lumbar sprains and strains, or Lumbago / Backache and 10 visits over 8 weeks for shoulder impingement syndrome. CA MTUS - Physical Medicine: Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home physical medicine. In this case, there is no record of prior physical therapy progress notes with documentation of any significant improvement in the objective measurements (i.e. pain level, range of motion, strength or function) to demonstrate the effectiveness of physical therapy in this injured worker. Furthermore, there is no mention of the patient utilizing a HEP (home exercise program). There is no evidence of presentation of an acute or new injury with significant findings on examination to warrant any treatments. Additionally, the request for physiotherapy would exceed the guidelines recommendation. Therefore, the request is considered not medically necessary or appropriate in accordance with the guidelines.