

Case Number:	CM14-0076567		
Date Assigned:	07/18/2014	Date of Injury:	11/24/1999
Decision Date:	08/15/2014	UR Denial Date:	05/01/2014
Priority:	Standard	Application Received:	05/27/2014

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 male with a date of injury of 11/24/99. He has been complaining of neck and back pain with radiation to the bilateral upper extremities down to arms and right thumb as well as to the bilateral lower extremities down to feet, associated with tingling / numbness in the left leg. Exam has revealed positive SLR bilaterally. Cervical spine flexion 40, extension 10, and lateral bending 5 degrees. Strength testing revealed weakness at the bilateral biceps, triceps and wrist extensors 4/5. Sensation was decreased in the bilateral C5 & 6 distributions and in the lower extremities. Medications include Ultracet, Voltaren XR, and Omeprazole. He is diagnosed with lumbar spine herniated nucleus pulposus L2-L3, L3-L4, and L4-L5, sprain / strain of cervical and lumbar spine, left leg radiculitis, left shoulder impingement syndrome, acromioclavicular joint hypertrophy, right wrist strain/sprain, myofascial pain and DeQuervain's tenosynovitis. The plan was physical therapy of the lumbar spine two times a week for four weeks. A previous request for physical therapy of the lumbar spine was not certified on 5/1/14, due to a lack of medical necessity per guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy of the Lumbar Spine two times a week for four weeks: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 288.

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

Decision rationale: As per the MTUS Chronic Pain 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 MTUS Chronic Pain Guidelines recommends 9-10 visits for myalgia and myositis, and 8-10 visits for neuralgia, neuritis, and radiculitis. 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 home exercise program (At this juncture, this patient should be well-versed in an independently applied home exercise program, with which to address residual complaints, and maintain functional levels). 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 might exceed the MTUS Chronic Pain Guidelines' recommendation. Therefore, the request is considered not medically necessary and appropriate.