

Case Number:	CM14-0201771		
Date Assigned:	12/12/2014	Date of Injury:	04/11/2002
Decision Date:	04/13/2015	UR Denial Date:	11/21/2014
Priority:	Standard	Application Received:	12/02/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 sustained an industrial injury reported on 4/11/2002. She reported consistent and severe radiating neck pain, and pain in both hands, right > left. The diagnoses were noted to include bilateral cervical spine sprain with foraminal stenosis; displacement of cervical intervertebral disc without myelopathy; and cervical radiculopathy. Treatments to date have included consultations; diagnostic imaging studies; and medication management. The work status classification for this injured worker (IW) was noted to be she was returned to work. On 11/21/2014, Utilization Review (UR) modified, for medical necessity, the request, made on 11/17/2014, for 12 sessions of physical therapy, for cervical, to include: evaluation, therapeutic exercises, manual therapy, ultrasound, electrical stimulation, mechanical traction, and massage - to 8 sessions to include: evaluation, therapeutic exercises, manual therapy, mechanical traction and 4 visits of massage. The Medical Treatment Utilization Schedule, chronic pain medical treatment guidelines, physical therapy in the chronic phase of treatment, sprains/strains, massage therapy; and the Official Disability Guidelines, neck & upper back chapter, active treatment versus passive treatment modalities, sprains/strains, ultrasound, home cervical patient controlled traction, electrical muscle stimulation, were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy 12 visits with PT Evaluation; Therapeutic Exercises; Manual Therapy; Ultrasound; Electrical Stimulation; Mechanical Traction; and Massage: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chronic Pain Treatment Guidelines Physical Therapy. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official disability guidelines Neck and Upper Back (Acute and Chronic), Physical Therapy.

Decision rationale: Based on the progress report dated 11/14/14, the patient presents with neck pain radiating into the bilateral upper extremity. The request is for, physical therapy 12 visits with PT evaluation; therapeutic exercises; manual therapy; ultrasound; electrical stimulation, mechanical traction; and massage. The patient's diagnoses per Request for Authorization form dated 11/21/14 include cervical spine strain, displacement of cervical intervertebral disc without myelopathy, and cervical radiculopathy. Patient's medications include Celebrex, Vicodin, and Flexeril. MTUS Guidelines, pages 98-99, state, "Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. As per ODG-TWC, Neck and Upper Back (Acute and Chronic), Physical Therapy, Displacement of cervical intervertebral disc (ICD9 722.0): Medical treatment: 10 visits over 8 weeks. Treater has not provided reason for the request, nor provided a complete treatment history addressing benefits. Per progress report dated 11/14/14, treater states, "Will need additional PT." Given patient's diagnosis, a short course of physical therapy would be indicated. However, treater does not discuss any flare-ups, explain why on-going therapy is needed, or reason the patient is unable to transition into a home exercise program. Furthermore, the request for additional 12 sessions would exceed what is allowed by MTUS for the patient's condition. Therefore, the request IS NOT medically necessary.