

Case Number:	CM14-0208312		
Date Assigned:	12/19/2014	Date of Injury:	11/24/1999
Decision Date:	02/12/2015	UR Denial Date:	12/08/2014
Priority:	Standard	Application Received:	12/11/2014

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 Internal 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 injured worker (IW) is a 64-year-old woman with a date of injury of November 23, 1999. The mechanism of injury was not documented in the medical record. The injured worker's working diagnoses are cervical myofascial sprain/strain; degenerative disc disease at L4-L5 and L5-S1; status post thoracic lumbar fusion with indications not clear and painful retained hardware, lumbar spine; right cubital tunnel syndrome, status post arthroscopic surgery; and bilateral carpal tunnel syndrome, status post right carpal tunnel release. Pursuant to the progress note dated November 20, 2014, the IW complains of pain in her neck, mid back, low back, and bilateral hands. She continues to have significant pain to her entire spine with pain radiating down her right upper extremity. She recently received a walker with a seat, which has helped with ambulation. Examination of the cervical spine reveals spasms and paraspinal tenderness. Examination of the lumbar spine reveals spasms about the mid thoracic and lower lumbar regions. Pain is increased with motion. There is paraspinal tenderness upon palpation about the thoracolumbar area. Straight leg test is positive on the left. Examination of the hands reveals tenderness over scars bilaterally. Grip strength is weak bilaterally, however, the IW is able to make a complete fist. There are scattered physical therapy notes in the medical record what duration and frequency are visibly absent. There was no documentation with clinical rationale or indications for additional physical therapy. The medical record does not provide the total number of physical therapy visits rendered to the IW over the course of the injury. There is no documentation evidencing objective functional improvement associated with prior physical therapy. The current request is for physical therapy two times per week for six weeks of the cervical spine, lumbar spine and bilateral.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy 2 x 6 weeks for the cervical spine, lumbar spine and bilateral hands:

Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy Page(s): 474.

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 (ODG); Pain Section, Physical Therapy.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, physical therapy two times per week for six weeks of the cervical spine, lumbar spine and bilateral hands is not medically necessary. Patients should be formally assessed after a six visit clinical trial to see if the patient is moving in a positive direction, no direction or negative direction (prior to continuing with physical therapy). When treatment duration and/or number of visits exceed the guidelines, exceptional factors should be noted. In this case, the injured worker's working diagnoses are cervical myofascial sprain/strain; degenerative disc disease at L4 - L5 and L5 - S1; status post thoracic lumbar fusion with indications not clear and painful retained hardware, lumbar spine to knee; right cubital tunnel syndrome, status post arthroscopic surgery; bilateral carpal tunnel syndrome status post right carpal tunnel release. The worker is a 64-year-old woman with a date of injury November 24, 1999. The injured worker continues to have significant pain in her entire spine radiating down her right upper extremity and pain radiating to bilateral lower extremities. An authorization was submitted for additional physical therapy 2 times per week for six weeks. However, there was no documentation with a clinical rationale or indications for additional physical therapy. The medical record does not provide the total number of physical therapy visits rendered to the injured worker over the course of the injury. There are scattered physical therapy notes in the medical record but duration and frequency of total visits are visibly absent. Consequently, absent clinical information to support additional physical therapy and documentation evidencing objective functional improvement associated with prior physical therapy, physical therapy two times per week for six weeks of the cervical spine, lumbar spine and bilateral hands is not medically necessary.