MAXIMUS Federal Services

Case Number:	CM15-0000579		
Date Assigned:	01/12/2015	Date of Injury:	10/06/2013
Decision Date:	03/06/2015	UR Denial Date:	12/12/2014
Priority:	Standard	Application Received:	01/02/2015

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 female patient, who sustained an industrial injury on 10/06/2013. A primary treating visit dated 10/28/2013 reported the injured worker still off from work wtih complaint of headache and nausea when she looks downward. She reports the inability to read or do housework. She complains of neck and back pain along with a vibrating sensation to the left little toe. On 12/12/2014 Utilization Review non-certified the request for physical therapy twice weekly for 6 weeks, noting the ACOEM and ODG Guidelines were cited. She is currently taking Tylenol and Robaxin; in additon to the use of heat and cold application. She is noted with an allergy to ASA. The following visit dated 11/22/2013 described her being status post 4 sessions of physical therapy to include electric stimulation, heat, ice,massage and stretching with the pain persisting. A physical therapy re-evaluation dated 01/13/2014 under the diagnoses cervicalgia and joint shoulder pain found the patient with subjective complaint of upper extremity pain and dysfunction. Objective examination noted cervical spine range of motion all with improvement since 12/13/2013. The assessment reported the patient requiring skilled physical therapy in conjunction with a home exercise program with note of patient being an overall good potential for rehabilitation. On 12/12/2014 Utilization Review non-certified the request for additional physical therapy twice weekly for 6 weeks, noting the ACOEM and ODG Guidelines. The injured worker submitted an application for IMR for reveiw of the requested services.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy, twice weekly for six 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 (ODG), Neck & Upper Back Chapter, Physical Therapy Section

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy, pages 98-99.

Decision rationale: Physical therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. However, there is no clear measurable evidence of progress with the PT treatment already rendered including milestones of increased ROM, strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints, clinical findings, and work status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. The Chronic Pain Guidelines allow for 9-10 visits of physical therapy with fading of treatment to an independent self-directed home program. It appears the employee has received significant therapy sessions without demonstrated evidence of functional improvement to allow for additional therapy treatments. There is no report of acute flare-up, new injuries, or change in symptom or clinical findings to support for formal PT in a patient that has been instructed on a home exercise program for this chronic injury. Submitted reports have not adequately demonstrated the indication to support further physical therapy when prior treatment rendered has not resulted in any functional benefit. The Physical Therapy, twice weekly for six weeks is not medically necessary and appropriate.