

Case Number:	CM15-0009899		
Date Assigned:	01/27/2015	Date of Injury:	11/26/2012
Decision Date:	03/19/2015	UR Denial Date:	12/22/2014
Priority:	Standard	Application Received:	01/16/2015

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: Maryland, Texas, Virginia

Certification(s)/Specialty: Internal Medicine, Allergy and Immunology, Rheumatology

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 56 year old male, who sustained an industrial injury on 11/26/12. He has reported neck, back, right hip and bilateral wrist pain. The diagnoses have included cervical, thoracic and lumbar spine strain/sprain with lumbar radiculopathy, bilateral wrist strain/sprain, right hip strain/sprain with lumbar radiculitis, depression, and anxiety and sleep disorder. Treatment to date has included medications, diagnostics, lumbar injections, acupuncture, extracorporeal shockwave procedures, and physical therapy 14 sessions. Currently, the IW complains of headaches, pain in the neck, back and right hip/thigh. Magnetic Resonance Imaging (MRI) of lumbar spine dated 10/30/13 revealed disc desiccation, restricted range of motion in flexion and extension which may reflect myospasm posterior disc herniation. He complains of pain and numbness in bilateral wrists/hands. The headaches were rated 8/10 which has increased from 6/10. The neck and upper back pain was rated 6/10 which has increased from 5/10. The pain in the lower back was rated 7/10 which has increased from 6/10. The pain in bilateral wrists and hand pain was rated 5/10 which has increased from 4/10 and the pain in the right hip/thigh was rated 4/10 which has decreased from 5/10. The physical exam of the cervical spine revealed tenderness to palpation over the paraspinal muscles, restricted range of motion and cervical compression test was positive. The lumbar spine had tenderness to palpation over the paraspinal muscles and straight leg test was positive bilaterally. The thoracic spine had restricted range of motion, bilateral wrists and right hip had tenderness to palpation. The injured worker stated that the physical therapy treatments help and the pain and tenderness has decreased. He is pending follow up with the spinal surgeon. Treatment was to continue medications and physical therapy.

On 1/27/15 Utilization Review modified 12 physical therapy sessions modified to a certification of 2 physical therapy sessions with the 10 remaining sessions recommended non-certified , noting that it is reasonable to offer a few additional sessions to reinforce the Home Exercise Program (HEP) or actually implement them. The (MTUS) Medical Treatment Utilization Schedule guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

12 physical therapy sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 65-194, Chronic Pain Treatment Guidelines Physical Therapy, Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Low Back - Lumbar & Thoracic (Acute & Chronic), Physical Therapy, ODG Preface Physical Therapy

Decision rationale: California MTUS guidelines refer to physical medicine guidelines for physical therapy and recommends as follows: Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Additionally, ACOEM guidelines advise against passive modalities by a therapist unless exercises are to be carried out at home by patient. ODG quantifies its recommendations with 10 visits over 8 weeks for lumbar sprains/strains and 9 visits over 8 weeks for unspecified backache/lumbago. Regarding physical therapy, ODG states 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 a negative direction (prior to continuing with the physical therapy); & (6) When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted. The request for 12 sessions is in excess of guidelines. ODG does recommend that post-surgical thoracic/lumbar physical therapy range from 16-30+ sessions over 8-16 weeks. The patient has had physical therapy in the past (14 sessions) and there has been no new injuries. There is no mention of an ongoing home exercise program. The request was modified to 2 sessions to allow for reinforcement of previous physical therapy home exercise program which is appropriate. As such, the request for 12 Physical Therapy sessions is not medically necessary.