

Case Number:	CM15-0193335		
Date Assigned:	10/07/2015	Date of Injury:	01/21/2013
Decision Date:	11/16/2015	UR Denial Date:	09/10/2015
Priority:	Standard	Application Received:	10/01/2015

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, Indiana, New York
 Certification(s)/Specialty: Internal Medicine

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 55 year old female, who sustained an industrial injury on 1-21-2013. The injured worker was diagnosed as having displacement of cervical intervertebral disc without myelopathy, displacement of lumbar intervertebral disc without myelopathy, and internal derangement of shoulder. Treatment to date has included diagnostics, right carpal tunnel release, right shoulder surgery in 10-2013, lumbar epidural steroid injection, and medications. Pain management progress report (7-22-2015) noted complaints of increased neck pain, associated cervicogenic headaches, and radiating pain down both upper extremities and numbness in the hands. Her pain was rated 8 out of 10. She reported continued pain in her low back and right shoulder. It was documented that she recently completed outpatient physical therapy. She reported sleeping poorly and "continues to limit her abilities to perform ADLs", unspecified. Her current medications were documented as Ultram ER, Anaprox DS, and Prilosec. Exam of the cervical spine noted decreased range of motion, strength 4+ in the right upper extremity, 5- in the left upper extremity, decreased sensation in the C5-6 distribution bilaterally, right grip (dominant) 20-24-18 and left 30-26-30. Exam of the right shoulder noted decreased range of motion and tenderness along the joint line. Exam of the lumbar spine noted tenderness to palpation of the bilateral lumbar musculature with increased muscle rigidity, numerous trigger points, decreased range of motion, and decreased sensation and 4+ strength in the bilateral L5-S1 dermatomes. It was documented that she had "extensive conservative management of at least 40 chiropractic treatments with physical therapy modalities, but remains symptomatic". The PR2 dated 6-22-2015 noted participation in "multiple sessions of physical therapy and has shown only mild functional improvement". Only physical therapy notes regarding right hand

therapy (status post right carpal tunnel release) were submitted, noting at least 6 sessions through 6-02-2015, noting symptoms "unchanged". The current treatment plan included physical therapy, 2x3, non- certified by Utilization Review on 9-10-2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 2 times a week for 3 weeks (2x3): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Physical therapy.

Decision rationale: Pursuant and to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, physical therapy two times per week times three weeks 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 exceeds the guideline, exceptional factors should be noted. In this case, the injured worker's working diagnoses are cervical spine herniated disc with radiculopathy; lumbar spine herniated disc with radiculopathy; right shoulder internal derangement; bilateral lateral epicondylitis; right carpal tunnel syndrome; secondary sleep deprivation; and secondary stress, anxiety and depression. Date of injury is January 21, 2013. Request for authorization is September 2, 2015. There is a single progress note by the requesting provider dated June 22, 2015. There was no contemporaneous clinical documentation by the requesting provider honor about September 2, 2015. According to the June 22, 2015 progress note, the injured worker requested a one-day multidisciplinary evaluation for a functional restoration program. Subjectively, the injured worker had complaints referable to the neck, low back, right shoulder, wrist and elbow. There was no clinical documentation indicating what anatomical region was to be addressed with physical therapy. The injured worker is status post carpal tunnel release with physical therapy documentation referable to the wrist only. There is no clinical discussion, indication or rationale for additional physical therapy. Based on the clinical information in the medical record, peer-reviewed evidence-based guidelines, no contemporaneous clinical documentation on or about the date of request for authorization (September 2, 2015), and no clinical discussion, indication or rationale for additional physical therapy or the anatomical region to be treated, physical therapy two times per week times three weeks is not medically necessary.