

Case Number:	CM15-0204798		
Date Assigned:	10/21/2015	Date of Injury:	05/28/2003
Decision Date:	12/03/2015	UR Denial Date:	10/06/2015
Priority:	Standard	Application Received:	10/19/2015

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 individual who sustained an industrial injury on 5-28-03. The medical records indicate that the injured worker was being treated for lumbago; carpal tunnel syndrome; cervicalgia; other general symptoms. Currently (9-28-15) there was ongoing pain to the neck, low back and right knee. The pain level of the neck and low back was 7 out of 10. She has difficulty sleeping. On physical exam of the cervical spine the range of motion was restricted, paravertebral muscles reveal spasm, tenderness and tight muscle band bilaterally; lumbar spine revealed restricted range of motion, on palpation there was muscle spasm, hypertonicity and tenderness bilaterally. She can walk on heel but not on toes. Treatments to date include home exercise program twice per day which relaxes her body; transcutaneous electrical nerve stimulator unit; physical therapy (8 out of 8 sessions completed per 8-31-15 note and she still had hypertonicity in her trapezius muscles and the right leg was getting stronger from therapy but she is favoring her left leg); medication: Flexeril, tramadol, nortriptyline. The request for authorization was not present. On 10-6-15 Utilization Review non-certified the request for physical therapy 2 times a week for 3 weeks for the cervical, lumbar spine and right knee.

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional physical therapy 2x a week for 3 weeks to the cervical/lumbar spine and right knee: 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 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 functional 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 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 P&S 2003 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 as the patient continues to be not working. The Additional physical therapy 2x a week for 3 weeks to the cervical/lumbar spine and right knee is not medically necessary and appropriate.