

Case Number:	CM15-0050494		
Date Assigned:	03/24/2015	Date of Injury:	06/05/2009
Decision Date:	05/01/2015	UR Denial Date:	02/17/2015
Priority:	Standard	Application Received:	03/17/2015

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: Georgia, California, Texas

Certification(s)/Specialty: Preventive Medicine, Occupational 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 (IW) is a 48 year old female who sustained an industrial injury on 06/05/2009. She reported injury to the neck back, shoulders, eyes, right lower extremity, sleep and sexual dysfunction. The injured worker was diagnosed as having cervical intervertebral disc displacement, without myelopathy; brachial neuritis or radiculitis; carpal tunnel syndrome; lumbar intervertebral disc displacement without myelopathy; and neuritis/radiculitis thoracic/lumbosacral. Treatment to date has included an anterior cervical discectomy and fusion C5-6, C6-7 (09/15/2014) testing, and medications. Currently, the injured worker complains of numbness and tingling left anterior wrist, left anterior hand, left posterior wrist and hand, left lumbar, left sacroiliac, lumbar, right lumbar, right sacroiliac, right buttock, right posterior leg, right posterior knee, right calf, right ankle, right foot, right anterior leg, right anterior knee, right shin, and right ankle pain. The current treatment plan includes medications, a home interferential stimulator unit 60 day trial, and physical therapy 3x4. This request for authorization is for Physical Therapy 3 times weekly for 4 weeks (12 sessions), cervical deep neck flexor stabilization program, upper/lower extremity strengthening program with instruction for home exercise.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy 3 times weekly for 4 weeks (12 sessions), Cervical deep neck flexor stabilization program, upper/lower extremity strengthening program with instruction for home exercise: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26.

Decision rationale: The injured worker is s/p cervical fusion in September 2014. Postoperative physical therapy was initiated in December 2014, with objective evidence of improvement based upon subsequent range of motion measurements. The 6 month postoperative physical therapy treatment period recommended by MTUS has elapsed. A home exercise program is in place. Medical necessity is not established for continued skilled therapy at this point in care. Therefore, the request is not medically necessary.