

Case Number:	CM14-0146751		
Date Assigned:	09/18/2014	Date of Injury:	10/20/1999
Decision Date:	10/16/2014	UR Denial Date:	09/02/2014
Priority:	Standard	Application Received:	09/09/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 53 year-old patient sustained an injury on 10/20/1999. Request(s) under consideration include 8 physical therapy for the right upper extremity 8 visits, as an outpatient for submitted diagnosis of cervical stenosis at C5-6 and C6-7, lumbar radiculopathy, years status post bilateral carpal tunnel release, and ulnar release, status post remote left shoulder surgery. Report of 8/18/14 from the provider noted the patient with ongoing chronic pain symptoms. Medications list Zipsor, Soma, Trazodone, Norco, and MS Contin. Exam showed lumbar spine tenderness with limited range in all directions; positive bilateral SLR (no degrees specified); antalgic gait; left lumbar spasm; diffuse bilateral motor weakness of lower extremities of 3+ to 5/5; diffuse decreased sensation at L2, L3, L4, and L5 dermatomes with 1+ DTRs. Diagnoses include ventral hernia; lumbar sprain/strain; failed back syndrome; lumbar DDD/ lumbar radiculopathy. Treatment included medication refills; caudal epidurals; PT; UDS. Peer review with chiropractic provider in same office representing patient noted patient with ongoing symptom complaints without noted new injuries for remote previous surgeries. The request(s) for 8 physical therapy for the right upper extremity 8 visits, as an outpatient for submitted diagnosis of cervical stenosis at C5-6 and C6-7, lumbar radiculopathy, years status post bilateral carpal tunnel release, and ulnar release, status post remote left shoulder surgery was 9/2/14 non-certified on citing guidelines criteria and lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

8 physical therapy for the right upper extremity between 8/29/2014 and 10/13/2014: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM - [https://www.acoempracquiges.org/Cervical and Thoracic Spine; Table 2, Summary of Recommendations, Cervical and Thoracic Spine Disorders](https://www.acoempracquiges.org/Cervical%20and%20Thoracic%20Spine;Table%202,Summary%20of%20Recommendations,Cervical%20and%20Thoracic%20Spine%20Disorders)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy Page(s): 98-99.

Decision rationale: Physical therapy (PT) 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 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 8 physical therapy for the right upper extremity 8 visits, as an outpatient for submitted diagnosis of cervical stenosis at C5-6 and C6-7, lumbar radiculopathy, years past status post bilateral carpal tunnel release, and ulnar release, status post remote left shoulder surgery between 8/29/2014 and 10/13/2014 are not medically necessary.