

Case Number:	CM14-0148733		
Date Assigned:	09/18/2014	Date of Injury:	06/24/2008
Decision Date:	10/17/2014	UR Denial Date:	08/08/2014
Priority:	Standard	Application Received:	09/12/2014

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:

The injured worker is a 54-year-old female who reported an injury on 06/24/2008. The mechanism of injury was not submitted for review. The injured worker has diagnoses of chronic low back pain without solid evidence of lumbar radiculopathy. The injured worker underwent left shoulder arthroscopy. Past medical treatment consisted of use of a TENS unit, physical therapy, medial branch blocks and medication therapy. Medications include Ultram, Flexeril, Wellbutrin, gabapentin and Celebrex. On 07/22/2014, the injured worker complained of back pain. examination of the lumbar/thoracic spine revealed that there was tenderness in the paralumbar musculature, positive tenderness in the parathoracic musculature, negative for tenderness in the posterior superior iliac spine region; positive muscle spasm in the paralumbar musculature. Motor testing was 5/5 in all muscle groups of the lower extremities. Deep tendon reflexes were 2+. Range of motion of the lumbar spine revealed a forward flexion of 60 degrees, extension of 30 degrees, lateral tilt to the left 30 degrees and lateral tilt to the right of 30 degrees. The medical treatment was for the injured worker to continue with physical therapy and the use of cyclobenzaprine. The rationale and Request for Authorization form were not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy 3 times a week for 6 weeks, low back/lumbar, left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Physical Medicine.

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

Decision rationale: The request for physical therapy 3 times a week for 6 weeks for the low back/lumbar and left shoulder is not medically necessary. The California MTUS states that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. The submitted documentation lacked any evidence of the injured worker's prior course of physical therapy, as well as the efficacy of prior therapy. The guidelines recommended up to 10 visits of physical therapy, the amount of therapy visits that have already been completed is unclear. Additionally, the request, as submitted is for 18 physical therapy sessions, exceeding the recommended guidelines. Given the above, the injured worker is not within the MTUS recommended guidelines. As such, the request is not medically necessary. Furthermore, the provider did not submit a rationale as to how physical therapy would help the injured worker with any functional deficits.

Cyclobenzaprine 7.5mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Muscle relaxants (for p.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Page(s): 41.

Decision rationale: The request for cyclobenzaprine 7.5 mg is not medically necessary. The California MTUS Guidelines recommend cyclobenzaprine as an option for short term course of therapy. The greatest effect of the medication is in the first 4 days of treatment, suggesting that shorter courses may be better. The submitted documentation indicated the injured worker has been on this medication since at least 11/2013. The request for additional use of the medication would exceed the guideline recommendations. Furthermore, the efficacy of the medication was not submitted for review. Given the above, the injured worker is not within the MTUS recommended guidelines. As such, the request is not medically necessary.