

Case Number:	CM14-0149793		
Date Assigned:	09/18/2014	Date of Injury:	12/19/2011
Decision Date:	10/17/2014	UR Denial Date:	08/27/2014
Priority:	Standard	Application Received:	09/15/2014

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 Occupational Medicine and is licensed to practice in Texas. 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 patient is a 57 year old female with an injury date of 12/19/11. Per the 06/10/14 QME report provided by [REDACTED], the patient presents with posterior neck and bilateral upper back pain; pulling stabbing pain with pressure in the upper back radiating to the lower back; stabbing pain in the right shoulder; medial and lateral right elbow; tingling pain in the right wrist; lower back pain radiating to the right buttock; and sharp, stabbing pain in the left hip. Pain is rated 4-5/10. Examination of the cervical spine reveals flexion 30 with guarding and posterior neck pain and limited range of motion of the wrists; for the lumbar spine 60 flexion with muscle guarding and right lower back pain; straight leg raise is positive on the right for right posterolateral calf pain. The patient's diagnoses include: Degenerative disc disease C6-7, Status post open reduction and internal fixation, comminuted distal radius fracture right wrist 12/23/11, daily headaches, sleep disturbance due to pain, lower back pain with left groin and left lower extremity pain. The utilization review being challenged is dated 08/27/11. Only the 06/10/14 QME was provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional physical therapy 2 times a week for 6 weeks, neck & upper extremities, quantity 12: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine.

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

Decision rationale: Within the medical records provided for review, the treater has not documented or discussed the reason for additional physical therapy nor have any records been provided to show an assessment demonstrating improvement or maintenance of function. The MTUS Chronic Pain Guidelines page 8 require the treater to monitor the patient's progress and make appropriate recommendations. Furthermore, the patient is not post-operative (wrist surgery was from 2011) and for physical therapy treatments for this type of condition, the MTUS Chronic Pain Guidelines allows up to 10 sessions. The current request exceeds this. As such, the request is not medically necessary and appropriate.