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| Case Number: | CM14-0214860 | | |
| Date Assigned: | 01/07/2015 | Date of Injury: | 02/14/2014 |
| Decision Date: | 02/24/2015 | UR Denial Date: | 12/05/2014 |
| Priority: | Standard | Application Received: | 12/22/2014 |

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. 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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & Gen Prev Med

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 patient is a 38 year old employee with date of injury of 2/14/14. Medical records indicate the patient is undergoing treatment for myofascial pain and cervical and lumbar strain. Subjective complaints include pain in neck, right wrist pain, bilateral shoulders and lumbar spine. She describes her pain as aching, throbbing which is made worse with flexion or repetitive activity, rotation or reaching overhead. She has low back pain at the waist which will occasionally radiate to the gluteal and posterior leg. Objective findings include on exam: cervical flexion 30; extension 20; left and right tilt; 25; rotation right; 40 and left rotation, 35. She has normal motor strength and sensation in bilateral upper extremities. In her lumbar spine: flexion, 30; extension, 20 and right and left tilt, 15. Negative straight leg raise. Tenderness in the paraspinal musculature. An MRI of the cervical spine was negative. Treatment has consisted of Acupuncture and physical therapy. She discontinued all medications. The utilization review determination was rendered on 12/5/14 recommending non-certification of Physical therapy, 12 sessions.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy x12: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): page(s) 65-194; 287-315, Chronic Pain Treatment Guidelines Physical Therapy, Physical Medicine Page(s): -page(s) 98-99. Decision based on Non-MTUS Citation Neck and Upper Back & Low back , Physical Therapy

Decision rationale: MTUS refer to physical medicine guidelines for physical therapy and recommends as follows: “Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine.” Additionally, ACOEM guidelines advise against passive modalities by a therapist unless exercises are to be carried out at home by patient. ODG writes regarding neck and upper back physical therapy, Recommended. Low stress aerobic activities and stretching exercises can be initiated at home and supported by a physical therapy provider, to avoid debilitation and further restriction of motion. ODG further quantifies its cervical recommendations with Cervicalgia (neck pain); Cervical spondylosis and low back ache = 9 visits over 8 weeks Sprains and strains of neck and Low Back = 10 visits over 8 weeks Regarding physical therapy, ODG states “Patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy); & (6) When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted.” At the conclusion of this trial, additional treatment would be assessed based upon documented objective, functional improvement, and appropriate goals for the additional treatment. Per guidelines, an initial trial of six sessions is necessary before additional sessions can be approved. The request for 12 sessions is in excess of guidelines. The treating physician does not detail extenuating circumstances that would warrant exception to the guidelines. As such, the request for physical therapy twelve sessions is not medically necessary.