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| Case Number: | CM15-0008529 | | |
| Date Assigned: | 01/26/2015 | Date of Injury: | 07/29/2010 |
| Decision Date: | 03/26/2015 | UR Denial Date: | 12/19/2014 |
| Priority: | Standard | Application Received: | 01/15/2015 |

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: California, Arizona
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 61-year-old male who reported an injury on 07/29/2010. The mechanism of injury was not stated. The current diagnoses include neck pain and cervical radiculopathy. The injured worker presented on 11/10/2014, with complaints of persistent neck and low back pain. The injured worker also reported radiating symptoms into the upper and lower extremities. The injured worker had completed a course of physical therapy. The current medication regimen includes Norco, Soma, Flexeril, Xanax, nortriptyline, Reglan, Ambien, and Terocin topical solution. Upon examination, there was diminished cervical range of motion, with tenderness to palpation, spasm, negative straight leg raise, diminished motor strength in the bilateral upper extremities, and diminished motor strength in the bilateral lower extremities. The recommendation included 6 sessions of physical therapy for the thoracolumbar spine. A Request for Authorization form was submitted on 12/09/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 6 session Lumbar, thoracic: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Physical Therapy, and Physical Medicine Guidelines

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

Decision rationale: The California MTUS Guidelines state 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. The injured worker has completed a previous course of physical therapy. However, there was no documentation of significant functional improvement. The injured worker should be well versed in a home exercise program. Given the above, the request is not medically appropriate at this time.