

Case Number:	CM15-0107830		
Date Assigned:	06/12/2015	Date of Injury:	04/20/2013
Decision Date:	07/13/2015	UR Denial Date:	05/22/2015
Priority:	Standard	Application Received:	06/04/2015

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

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 48 year old female, who sustained an industrial injury on February 27, 2015. She reported neck pain, cervical spine pain, thoracic spine pain, left wrist pain, low back pain, sacroiliac pain, buttock pain, bilateral knee pain and bilateral lower extremity pain. The injured worker was diagnosed as having brachial neuritis or radiculitis and cervical intervertebral disc disorder with myelopathy. Treatment to date has included diagnostic studies, physical therapy, medications and work restrictions. Currently, the injured worker complains of neck pain, cervical spine pain, thoracic spine pain, left wrist pain, low back pain, sacroiliac pain, buttock pain, bilateral knee pain and bilateral lower extremity pain. The injured worker reported an industrial injury in 2015, resulting in the above noted pain. She was treated conservatively without complete resolution of the pain. Evaluation on June 4, 2015, revealed continued pain as noted. The physician recommended continuing physical therapy. Physical therapy for the right arm and hand was requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 2 times a week for 3 weeks to the right arm and hand: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy, pages 98-99.

Decision rationale: Physical therapy 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 symptom complaints, clinical findings, and functional 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 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 Physical therapy 2 times a week for 3 weeks to the right arm and hand is not medically necessary or appropriate.