

Case Number:	CM15-0010110		
Date Assigned:	01/27/2015	Date of Injury:	09/18/2009
Decision Date:	03/17/2015	UR Denial Date:	12/24/2014
Priority:	Standard	Application Received:	01/16/2015

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: Maryland

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

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 male, who sustained an industrial injury on Sept 18, 2009. His diagnoses include cervical myospasms and lumbar radiculopathy. He has been treated with MRI, electrodiagnostic studies, muscle relaxant, proton pump inhibitor, and non-steroidal anti-inflammatory medications; a home exercise program, and physical therapy. On December 11, 2014, his treating physician reports continuing head, neck, bilateral elbows, bilateral wrists, and lower back pain, which is moderate to severe. The injured worker has numbness and tingling in his bilateral fingers with decreased grip strength. His back pain radiates into his bilateral lower extremities with numbness and tingling, which is greater on the left than the right. The cervical exam revealed tenderness to palpation of the left paraspinal musculature at the cervical 4-7 levels with myospasms, and restricted range of motion in all planes, greater on the left. The lumbar exam revealed paralumbar tenderness to palpation with myospasms, limited range of motion in all planes with pain at the extremes, normal deep tendon reflexes and muscle strengths, and a positive right straight leg raise. The treatment plan includes additional physical therapy for the cervical spine, muscle relaxant, proton pump inhibitor, and non-steroidal anti-inflammatory medications. On December 24, 2014 Utilization Review non-certified a prescription for 8 visits (2 times a week for 4 weeks) of physical therapy for the lower back, noting the lack of documentation of the total number or physical therapy sessions rendered to date, the date of the last therapy session. There was lack of documentation of objective measurements of the deficits in range of motion for which the requested treatment will address, and no indication of why the deficits could not be addressed by an independent home exercise program which should have

already been taught to the injured worker in the course of the initial therapy treatments. The California Medical Treatment Utilization Schedule (MTUS), ACOEM Guidelines and ODG-TWC (Official Disability Guidelines- Treatment in Workers' Compensation) was cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy 2 x 4: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Compensation (TWC), Online Edition, Chapter Low Back, Lumbar & Thoracic, Physical Therapy Guidelines

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

Decision rationale: Physical Therapy 2 x 4 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The documentation indicates that the patient reports that prior physical therapy provided him with temporary relief and increased range of motion, however once he completed therapy his pain gradually returned with spastic activity. The documentation is not clear on objective, measurable documentation of functional improvement. The documentation is not clear on how many prior therapy sessions the patient had. The MTUS allows up to 10 visits for this condition. It is not clear why the patient cannot perform a self directed home exercise program. The request as written does not specify a body part. Without clarification of amount of therapy, or measurements of functional improvement additional therapy cannot be certified and is not medically necessary.