

Case Number:	CM15-0011956		
Date Assigned:	01/29/2015	Date of Injury:	03/22/2013
Decision Date:	03/18/2015	UR Denial Date:	12/17/2014
Priority:	Standard	Application Received:	01/21/2015

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: New York

Certification(s)/Specialty: Internal 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 43 year old female with an industrial injury dated March 22, 2013. The injured worker diagnoses include chronic mechanical low back pain, facet syndrome, left sacroiliac joint dysfunction, and cervical spine radiculitis. She has been treated with diagnostic studies, radiographic imaging, chiropractic treatment, prescribed medications and periodic follow up visits. According to the primary treating physician note dated 8/28/14, the injured worker reported low back pain. Objective findings revealed tenderness over the paraspinal muscles, trapezius and parascapular muscles bilaterally. There was tenderness to palpitation over the cervical spine. Cervical compression test and shoulder depression were positive bilaterally. Lumbar exam revealed diffused tenderness to palpitation with articular fixations noted throughout the lumbar spine and left sacroiliac joint. There was moderate pain over the left sacroiliac joint with a positive Yeoman's faber test. The treatment plan on 8/28/14 was for chiropractic treatment for low back and home exercise therapy. The treating physician prescribed services for additional therapy sessions (type, frequency, and duration not specified). Utilization Review determination on December 17, 2014 denied the request for additional therapy sessions (type, frequency, and duration not specified), citing MTUS Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional Therapy sessions (type, frequency, and duration not specified): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy Page(s): 98 (pdf format).

Decision rationale: Per California MTUS Treatment Guidelines 2009, physical therapy is indicated for the treatment of musculoskeletal pain. Recommendations state that for most patients with more severe acute and subacute pain sessions are indicated as long as functional improvement and program progression are documented. 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. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. Medical necessity for the requested additional physical therapy sessions has not been established. There is no documentation of functional improvement from prior completed sessions. In addition the type, frequency, and duration of additional therapy sessions were not specified. Medical necessity for the requested service has not been established. The requested service is not medically necessary.