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| Case Number: | CM15-0091044 | | |
| Date Assigned: | 05/15/2015 | Date of Injury: | 12/06/2011 |
| Decision Date: | 06/18/2015 | UR Denial Date: | 04/29/2015 |
| Priority: | Standard | Application Received: | 05/11/2015 |

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 24 year old female, who sustained an industrial injury on 12/06/2011. The mechanism of injury was not made known. According to a progress report dated 01/08/2015, the injured worker complained of dull to sharp pain in the neck, occurring most of the time, radiating to the right arm with numbness and tingling into the right hand. She reported dull to sharp pain in the entire back, occurring most of the time, radiating to the right leg with numbness and tingling. Right shoulder pain was dull and occurred occasionally. Physical examination demonstrated tenderness to palpation with decreased range of motion. Diagnoses included myoligamentous strain of the cervical spine, myoligamentous strain of the lumbar spine by history and compression-contusion injury of the right shoulder. The injured worker was temporarily totally disabled. The treatment plan included continuance of physical therapy. According to a progress report dated 03/24/2015, present complaints and physical examination remained unchanged from the prior examination of 01/08/2015. Medications included Naproxen, Tizanidine, Omeprazole, Tramadol/acetaminophen, and Gabapentin/acetyl-L-carnitine. An authorization request submitted by the provider requested authorization for a follow up appointment, physical therapy for the lumbar spine, cervical spine and the right shoulder, a urine drug screen, Gabapentin and Acetyl-L-Carnitine. Currently under review is the request for physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 2-3 times a week for 4 weeks for the lumbar and cervical spine and the right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation.

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 chronic 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 chronic 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 2-3 times a week for 4 weeks for the lumbar and cervical spine and the right shoulder is not medically necessary and appropriate.