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| Case Number: | CM17-0010362 | | |
| Date Assigned: | 01/19/2017 | Date of Injury: | 10/25/2016 |
| Decision Date: | 02/14/2017 | UR Denial Date: | 12/20/2016 |
| Priority: | Standard | Application Received: | 01/16/2017 |

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: 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 54 year old male, who sustained an industrial injury on 10-25-2016, after a chair fell apart from underneath him and he fell backwards. The injured worker was being treated for lumbar muscle strain and neck muscle strain. Treatment to date has included diagnostics and medications. On 11-23-2016 (Doctor's First Report of Occupational Injury or Illness), the injured worker complains of pain and discomfort in the low back, rated 7-8 out of 10. The injured worker denied radiating symptoms or associated numbness or weakness. Pain was aggravated by any movement and was relieved by pain medications. Work status was documented as full duty prior to visit, although the injured worker was placed on modified activity through 12-05-2016. Current medications included Tramadol. Physical exam of the cervical spine noted moderate tenderness, full range of motion, strength 5 of 5 in the upper extremities, and normal sensation. Exam of the low back noted moderate tenderness and spasms, range of motion within normal limits, 5 of 5 strength in the bilateral lower extremities, and normal sensation. The injured worker was prescribed Mobisyl topical cream and Meloxicam. The treatment plan included physical therapy, 2x3. A Request for Authorization dated 11-23-2016 was noted for physical therapy, 2x3, for lumbar stabilization, core strengthening, pain relief, stretching, injury prevention techniques, and home exercise program; manual manipulation, modalities and therapies as tolerated, and physical therapy, 2x3, for cervical stabilization, stretching, strengthening, and pain relief; include home exercise program, manual manipulation, modalities, and therapies as tolerated. On 12-16-2016 Utilization Review non-

certified a request for physical therapy for the cervical spine, 2 times a week for 3 weeks, and physical therapy for the lumbar spine, 2 times a week for 3 weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy for the cervical spine 2 times a week for 3 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2016. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2016, Section(s): Physical medicine treatment. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck section, Physical therapy.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines 2016 and the Official Disability Guidelines, physical therapy for the cervical spine two times a week for three weeks is not medically necessary. Physical medicine encompasses interventions that are within the scope of various practitioners (including Physical Therapy, Occupational Therapy, Chiropractic, and MD/DO). Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) is not indicated for addressing chronic pain in most instances; refer to the specific modality within these guidelines (e.g., massage, ultrasound). 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. Active therapy requires an internal effort by the individual to complete a specific exercise or task. Refer to the specific intervention within these guidelines (e.g., exercise.) This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients should be formally assessed after a six visit clinical trial to see if the patient is moving in a positive direction, no direction or negative direction (prior to continuing with physical therapy). When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted. In this case, the injured worker's working diagnoses are lumbar muscle strain and neck muscle strain. Date of injury is October 25, 2016. Request for authorization is November 23, 2016. According to a November 22, 2016 first report of illness/injury, subjective complaints include low back pain without radiation. There is no VAS pain score. There are no neck complaints. Objectively, there is lumbar spine tenderness and spasm. Range of motion is within normal limits. There are no other physical examination findings documented. There is no neck examination. Medications are not documented. Work status documentation is illegible. The treatment plan includes physical therapy lumbar stabilization and cervical stabilization. There are no physical therapy progress notes in the medical record. The documentation indicates 8 previous physical therapy sessions were provided (per December 13, 2016 escalation notes). The documentation does not demonstrate objective functional improvement from the prior eight physical therapy sessions. The injured worker is being treated for cervical and lumbar muscle strain. The guidelines recommend up to 10 visits of physical therapy over eight weeks. There are no compelling clinical facts to support additional physical therapy. Consequently, six additional cervical physical therapy sessions are not

clinically indicated. Based on the clinical information in the medical record and the peer-reviewed evidence-based guidelines, physical therapy for the cervical spine two times a week for three weeks is not medically necessary.

Physical therapy for the lumbar spine 2 times a week for 3 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2016. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2016, Section(s): Physical medicine treatment. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back section, Physical therapy.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines 2016 and the Official Disability Guidelines, physical therapy for the lumbar spine two times a week for three weeks is not medically necessary. Physical medicine encompasses interventions that are within the scope of various practitioners (including Physical Therapy, Occupational Therapy, Chiropractic, and MD/DO). Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) is not indicated for addressing chronic pain in most instances; refer to the specific modality within these guidelines (e.g., massage, ultrasound). 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. Active therapy requires an internal effort by the individual to complete a specific exercise or task. Refer to the specific intervention within these guidelines (e.g., exercise.) This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients should be formally assessed after a six visit clinical trial to see if the patient is moving in a positive direction, no direction or negative direction (prior to continuing with physical therapy). When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted. In this case, the injured worker's working diagnoses are lumbar muscle strain and neck muscle strain. Date of injury is October 25, 2016. Request for authorization is November 23, 2016. According to a November 22, 2016 first report of illness/injury, subjective complaints include low back pain without radiation. There is no VAS pain score. There are no neck complaints. Objectively, there is lumbar spine tenderness and spasm. Range of motion is within normal limits. There are no other physical examination findings documented. There is no neck examination. Medications are not documented. Work status documentation is illegible. The treatment plan includes physical therapy lumbar stabilization and cervical stabilization. There are no physical therapy progress notes in the medical record. The documentation indicates 8 previous physical therapy sessions were provided (per December 13, 2016 escalation notes). The documentation does not demonstrate objective functional improvement from the prior eight physical therapy sessions. The injured worker is being treated for cervical and lumbar muscle strain. The guidelines recommend up to 10 visits of physical therapy over eight weeks. There are no compelling clinical facts to support additional lumbar physical therapy. Consequently, six additional lumbar physical therapy sessions are not clinically indicated. Based on the clinical information in the medical record and the peer-reviewed evidence-based guidelines, physical therapy for the lumbar spine two times a week for three weeks is not medically necessary.