

Case Number:	CM13-0019834		
Date Assigned:	10/11/2013	Date of Injury:	10/17/2012
Decision Date:	01/27/2014	UR Denial Date:	08/22/2013
Priority:	Standard	Application Received:	09/03/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, and is licensed to practice in California. 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 physician 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/services.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 47-year-old male sustained an injury on 10/17/12 while employed by [REDACTED]. Per report of 8/5/13 from [REDACTED], the patient complained of same unchanged low back, mid back and left shoulder pain. Exam findings noted decreased cervical and lumbosacral range of motion (no degree or plan specified) and positive left shoulder rotator cuff impingement with decreased motor strength (no muscle or grading specified). Diagnoses include Cervical and Thoracic sprain/strain; Right lumbosacral radiculopathy; Left shoulder rotator cuff bursitis, tendonitis, and partial tear. No mechanism of injury, medications, or surgical history documented. MRI of the Shoulder dated 6/28/13 noted partial tear on distal infraspinatus tendon; hypertrophic degenerative AC joint and subdeltoid bursitis. Treatment plan included cortisone injection in the left shoulder, electro-acupuncture treatment and continuation of exercise. Work status remains temporarily partially disabled with significant limitations of 5 lbs with no over the shoulder reaching and no back bending or twisting activities. It is unclear if the patient is working. The request for 8 Physical Therapy to the Left shoulder, Thoracic, Cervical and Lumbar spine was non-certified on 8/22/13 by [REDACTED], citing guidelines criteria and lack of medical information regarding scope, nature and outcome of prior therapy and conservative treatment options for this 2012 injury were not elaborated for review. There is a report dated 9/30/13 from [REDACTED] which describes the same unchanged pain symptoms, the identical objective findings with same severe work status limitations. Report dated 4/12/13 from [REDACTED] noted request for additional PT x 6 sessions with same modified duties. There is note from physical therapist, [REDACTED] reporting patient completed 5/6 therapy sessions. Report of 2/18/13 from [REDACTED] noted the patient to continue with home exercise program w

IMR ISSUES, DECISIONS AND RATIONALES

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

Eight physical therapy sessions of the left shoulder, thoracic, lumbar, and cervical region:
Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder Physical Therapy Guidelines Section, Low Back Physical Therapy Guidelines Section, and Neck & Upper Back Physical Therapy Guidelines Section.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy Part, Passive Therapy Section Page(s): 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 (range of motion), strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints, clinical findings, and work 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 Medical Treatment Guidelines allow for 9-10 visits of physical therapy with fading of treatment to an independent self-directed home program. It appears the employee has received at least 12 therapy sessions from February to April 2013 per reports by physical therapist and clinic notes without demonstrated evidence of functional improvement to allow for additional therapy treatments. The patient is now treating with [REDACTED] who has placed him on more restricted work limitations from 15 lbs. lifting and 25 lbs. pulling/pushing to current 5 lbs. work status with ongoing pain complaints. There is no report of acute flare-up and the patient has been instructed on a home exercise program for this October 2012 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 request for eight physical therapy sessions of the left shoulder/thoracic/lumbar/cervical region is not medically necessary or appropriate.