

Case Number:	CM13-0027486		
Date Assigned:	11/22/2013	Date of Injury:	03/15/2004
Decision Date:	01/28/2014	UR Denial Date:	08/22/2013
Priority:	Standard	Application Received:	09/21/2013

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 Family Practice and is licensed to practice in Texas. 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. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 53-year-old male who sustained a work-related injury on 03/15/2004. The patient's diagnoses include cervical disc fusion, status post left shoulder arthroscopy, right shoulder impingement, carpal tunnel syndrome, and depression. Request for authorization for physical therapy of the right shoulder 2 to 3 times per week for 6 weeks was made, as the patient is not a surgical candidate. The most recent progress report is dated 08/08/2013. Subjectively, the patient had complaints of neck pain, headaches, bilateral shoulder pain with limited range of motion, numbness, and continued low back pain with radiation into the right leg. Objective findings revealed cervical fusion from C4-7, restricted and painful range of motion of the bilateral shoulders, and positive impingement sign of the right shoulder. The treatment plan included request for authorization for physical therapy and a follow-up for medication management.

IMR ISSUES, DECISIONS AND RATIONALES

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

physical therapy two (2) to three (3) times a week for six (6) weeks: Upheld

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

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

Decision rationale: The Physician Reviewer's decision rationale: California MTUS Guidelines for physical medicine indicate 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. The clinical provided documented physical examination findings of right shoulder pain, limited range of motion, and positive impingement sign. However, there is lack of documentation of significant deficits or worsened symptoms that would support additional therapy. Furthermore, there is lack of documentation of the patient's response to and tolerance of prior physical therapy. Guidelines further indicate patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. At this distant juncture from injury and surgical intervention, the patient should be well versed in an independent, self-directed home exercise program to continue functional gains and pain reduction. As such, the request for physical therapy 2 to 3 times a week for 6 weeks is non-certified.