MAXIMUS Federal Services

Case Number:	CM13-0030478		
Date Assigned:	11/27/2013	Date of Injury:	03/24/2008
Decision Date:	01/10/2014	UR Denial Date:	09/04/2013
Priority:	Standard	Application Received:	09/26/2013

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:

The patient is a 48-year-old who sustained a work-related injury on 03/24/2008. The patient's diagnoses include arthritis of the acromioclavicular joint, displacement of cervical intervertebral discs without myelopathy, primary osteoarthritis of the shoulder region, degeneration of cervical intervertebral discs, degeneration of intervertebral discs, spinal stenosis in the cervical region, neck pain, neck strain, and shoulder joint pain. The clinical information indicates the patient is status post right shoulder arthroscopic surgery for subacromial impingement syndrome plus glenoid labral tear and undersurface tear of the supraspinatus tendon on 03/23/2012. The most recent evaluation dated 11/21/2013 indicates subjective complaints of right shoulder pain. Objective findings reveal tenderness to palpation of the paracervical muscles as well as the trapezius muscles, decreased range of motion, paracervical muscle spasm, positive impingement and shrug signs, enlarged acromioclavicular prominence, joint tenderness, positive adduction test, vertebral border tenderness, and parascapular muscle spasms. The treatment plan included dispensing of tramadol, Anaprox, and Protonix. The clinical information indicates the patient has recently undergone acupuncture with the most recent visit being 11/26/2013 at which time the patient reported cervical and right shoulder pain. Treatment at that time included electroacupuncture, myofascial release therapy, cupping, and infrared.

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional physical therapy, twice per week, for two weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Offidical Disability Guidelines, Neck & Upper Back Procedures Summary Section..

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

Decision rationale: The Physician Reviewer's decision rationale: According to the Chronin Pain Medical Treatment Guidelines, 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, and that it requires an internal effort by the individual to complete a specific exercise or task. Additionally, patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. The clinical information submitted for review indicates that the patient was recommended for physical therapy in 10/2013, but there are no initial or interim evaluations to determine the patient's progress. Furthermore, without objective findings documentation of exceptional factors and lack of documentation of functional deficit, there is no indication for additional physical therapy. Lastly, given that the patient has had extensive prior physical therapy sessions, there is no indication why the patient would continue to require formal physical therapy when a home exercise program has been instructed, and the patient should be well versed in said program to continue functional gains and pain reduction. The request for additional physical therapy, twice per a week for two weeks, is not medically necessary.

A consultation with a specialist for the left knee: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Offidical Disability Guidelines, Knee and Leg Procedures Summary Section.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343-345.

Decision rationale: The Physician Reviewer's decision rationale: According to the Knee Complaints Chapter of the ACOEM Practice Guidelines, referral for surgical consultation may be indicated for patients who have activity limitation for more than one month and there has been failure of an exercise program to increase range of motion and strength in the musculature around the knee. The clinical information submitted for review indicates the patient has had prior knee surgeries; however, the specifics are not detailed. Additionally, there is no subjective or objective documentation of flare up of knee symptoms or recent injury to support a consultation with a specialist for the left knee. The request as submitted did not indicate the type of specialist being requested. The request for a consultation with a specialist for the left knee is not medically necessary or appropriate.