

Case Number:	CM13-0052223		
Date Assigned:	12/27/2013	Date of Injury:	06/24/2011
Decision Date:	04/30/2014	UR Denial Date:	11/04/2013
Priority:	Standard	Application Received:	11/15/2013

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain Management 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 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/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:

This is a male patient with the date of injury of June 24, 2011. A utilization review determination dated November 4, 2013 recommends non-certification of physical therapy 2x4 left shoulder, thoracic spine, and lumbar spine. The previous reviewing physician recommended non-certification of physical therapy 2x4 left shoulder, thoracic spine, and lumbar spine due to lack of documentation of clinically meaningful benefit. A Progress Report amended October 31, 2013 identifies Subjective Complaints of neck pain, radiating to right shoulder blade, with constant throbbing pain, mid back pain, and low back pain radiating to bilateral lower extremities. Objective Findings identify positive cervical compression left, positive Jackson's left, positive Romberg's, restricted Range of Motion (ROM). Right shoulder positive apprehension, positive Codman's, positive Neer's sign, positive Hawkin's sign, and restricted ROM. Positive Tinel's right elbow and right wrist. T/S restricted ROM. Decreased sensation on left C5 dermatome. Mildly decreased sensation on L5 dermatome, left. Diagnoses identify thoracomyofasciitis, strain thoracic spine, impingement right shoulder, and strain lumbar spine. Treatment Plan identifies physical therapy two times per week for four weeks (2X4) for the right shoulder, thoracic spine, and lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY TWO (2) TIMES A WEEK FOR FOUR (4) WEEKS FOR THE LEFT SHOULDER, THORACIC SPINE AND LUMBAR SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL MEDICINE Page(s): 98-99.

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

Decision rationale: The request for physical therapy two (2) times a week for four (4) weeks for the left shoulder, thoracic spine, and lumbar spine, California MTUS cites that "patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels." Within the documentation available for review, there is no documentation of specific objective functional improvement with the previous Physical Therapy (PT) sessions. There is no documentation as to why the continued functional deficits cannot be addressed within the context of an independent home exercise program. In light of the above issues, the currently requested physical therapy two (2) times a week for four (4) weeks for the left shoulder, thoracic spine, and lumbar spine is not medically necessary.