

Case Number:	CM14-0001817		
Date Assigned:	07/11/2014	Date of Injury:	03/29/2000
Decision Date:	08/18/2014	UR Denial Date:	12/16/2013
Priority:	Standard	Application Received:	01/06/2014

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, and is licensed to practice in Illinois. 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:

The injured worker is a 64-year-old female who reported an injury on 3/29/00. The mechanism of injury was noted to be overuse with positioning at a computer. Her prior treatments were noted to be physical therapy, injections, and medication. Her diagnosis was noted to be bilateral shoulder pain. An orthopedic office visit dated 12/2/13 found the injured worker with complaints of right shoulder, left knee, and left shoulder pain. The injured worker rated the pain at 2-6/10 for the right shoulder and a 2-4/10 for the left shoulder. The injured worker rated pain in her left knee at 2-5/10. The injured worker stated symptoms were relieved with narcotic pain medication and rest. The examination of the right shoulder revealed tenderness to palpation over the subacromial bursa; no warmth. Sensation was intact to light touch and pain, and brisk bilateral radial pulse. The supraspinatus strength was 5/5 with pain, and infraspinatus strength was 5/5 with pain. Full active range of motion with normal extension, internal rotation, and external rotation was noted. The impingement test was positive. The left shoulder examination revealed no elicits pain to palpation. Sensation was intact to light touch and pain, and there was brisk bilateral radial pulse. The supraspinatus strength was 5/5 with pain, and infraspinatus strength was 5/5 with pain. There was full active range of motion with normal extension, internal rotation, and external rotation. The examination of the left knee found no knee effusion and an old healed surgical scar, anterior. Palpation to the knee noted tenderness over the bursa. The range of motion was limited with extension and flexion. The quadriceps muscle strength was 4/5 and hamstring muscle strength was 4/5. It was noted that the knee was stable without evidence of ligamentous injury or deficiency; mild click; and questionable mild increased varus/valgus instability. Sensation was intact to light touch with pain; brisk popliteal pulse; and 2/4 patellar tendon reflex.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY (PT) TREATMENT AND EVALUATION - 1 VISIT FOR THE UPPER BACK AREA: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines.

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

Decision rationale: The California MTUS Chronic Pain Medical Treatment Guidelines recommend physical medicine. 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. Injured workers are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. The physical medicine guidelines allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home physical medicine. The guidelines recommended 9 to 10 visits over 8 weeks. It was noted in the documentation submitted for review that the injured worker has had physical therapy. It is unknown how many therapy visits the injured worker has completed at the time of review. The most recent clinical document was dated 12/2/13. The physical evaluation was for the left, the left shoulder, and the left knee. The request was for the upper back area. All documented range of motion, muscle strength, and functional deficits are noted in the clinical evaluation for the shoulder and knee complaints. Without proper documentation and evaluation, a decision for therapy to the upper back area cannot be made without further objective data. Therefore, the request is not medically necessary.