MAXIMUS Federal Services

Case Number:	CM14-0009317		
Date Assigned:	02/14/2014	Date of Injury:	09/27/2009
Decision Date:	07/11/2014	UR Denial Date:	12/18/2013
Priority:	Standard	Application Received:	01/23/2014

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 Occupational Medicine, 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:

The patient is a 53-year-old female who has submitted a claim for right shoulder impingement syndrome, axial thoraco-lumbar pain syndrome, and status post implantation of a spinal cord stimulator, all associated with an industrial injury date of September 27, 2009. Medical records from 2013-2014 were reviewed. The latest progress report, dated 2/19/14, showed low back and right shoulder pain. There was decreased function of activities of daily living. She has poor sleep due to pain level. Increased pain was noted where stimulator has been implanted. Physical examination revealed stiffness and guarding of movements with assistance of a cane. Antalgic gait was noted on ambulation. There was decreased in muscle strength for both upper extremities. Range of motion was limited for both lower extremities and back. There was decreased sensation to light touch. Tenderness was noted in spinous processes from cervical to lumbar region. Treatment to date has included the implantation of a spinal cord stimulator (2011) and medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

OUTPATIENT PHYSICAL THERAPY TWO (2) TIMES A WEEK FOR SIX (6) WEEKS TO CERVICAL SPINE AND RIGHT SHOULDER: Upheld

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

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

Decision rationale: According to pages 98-99 of the California MTUS Chronic Pain Medical Treatment Guidelines, active therapy is recommended for restoring flexibility, strength, endurance, function, and range of motion. It can also alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. In addition, guidelines allow for fading of treatment frequency from up to three visits per week to one or less with the addition of active self-directed home physical medicine. Guidelines recommend 9-10 visits over 8 weeks for myalgia and myositis. In this case, a progress report dated 2/19/14 showed persistent pain with decreased functional activities. The rationale for requesting physical therapy is to increase strength and function of upper extremities. However, the present request of 12 sessions exceeds the guideline recommendation of 9-10 visits. There is no documented indication for the quantity of visits being requested. As such, the request is not medically necessary.