MAXIMUS Federal Services

| Case Number: | CM14-0018503 | | |
|---|---|---|---|
| Date Assigned: | 04/18/2014 | Date of Injury: | 03/08/2010 |
| Decision Date: | 06/30/2014 | UR Denial Date: | 02/05/2014 |
| Priority: | Standard | Application Received: | 02/13/2014 |

## 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 & 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 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 60 year of female who was injured on 03/08/2010. The mechanism of injury is unknown. Prior treatment history has included Norco as needed, 6 sessions of physical therapy for the upper and lower back, aquatic therapy, steroid injection into the right subacromial space dated 12/19/2013. The patient underwent a right shoulder arthroscopic surgery for repair rotator cuff on 07/19/2012. Diagnostic studies reviewed include Electrodiagnostic studies dated 04/22/2013 revealed mild chronic right C7 radiculopathy and mild bilateral CTS, right more than left. MRI of the cervical spine dated 03/13/2013 shows moderate degenerative disc disease superimposed on congenitally narrowed spinal canal; This causes spinal canal stenosis most prominent at C6-C7 where it is moderate in nature; and multineural foraminal narrowing. MRI of the lumbar spine dated 04/23/2012 demonstrates mild degenerative disc disease without significant spinal canal stenosis or neural foraminal narrowing. MRI of right shoulder on 01/31/2012 reveals full thickness tear supraspinatus tendon. PR2 dated 12/19/2013 indicates the patient to have complaints of right shoulder and low back pain especially with lifting. The patient cannot sleep due to pain. The patient denies numbness and tingling, dizziness or sensory change. Objective findings on exam revealed no redness, swelling, ecchymosis, gross deformity or atrophy noted on shoulder exam. The patient reports tenderness to the anterior right shoulder. Range of motion exhibits normal flexion, extension, abduction, adduction, internal and external rotation. The strength is 4/5 in the right shoulder with forward flexion and abduction. Sensation is intact in the upper extremity. Deep tendon reflexes are intact in the upper extremity. Special tests include: Hawkins test is positive on the right and negative on the left; Neer's test is positive on the right and negative on the left. The patient is diagnosed with cervical spinal stenosis, lumbar spondylosis and right shoulder arthroscopy with rotator cuff repair. The treatment and plan included MRI right shoulder without contrast; Docusate sodium, Soma 350 mg, Lidoderm

5% patch, hydrocodone acetaminophen (Norco10-325) and continue outpatient therapy as prescribed. Of note, the six sessions of physical therapy of upper and lower back was documented by prior review but there is no medical report provided in the records.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**PHYSICAL THERAPY TWO TIMES A WEEK FOR 3 WEEKS (2 X 3)TO THE UPPER AND LOWER BACK:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, PHYSICAL MEDICINE GUIDELINES, 98-99

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, PHYSICAL MEDICINE, 98-99

**Decision rationale:** According to the CA MTUS guidelines, physical medicine is recommended as a modality of treatment that is very important in reducing swelling, decreasing pain, and improving range of motion. It is important to allow for fading of treatment frequency (from up to 3 visits per week to 1 or less) plus active self-directed home physical medicine. For neuralgia, neuritis, and radiculitis unspecified, it is recommended from 8 to 10 visits over 4 weeks. The medical record documents the patient was diagnosed with cervical spinal stenosis, lumbar spondylosis and status post right shoulder arthroscopy with rotator cuff repair. The patient received 6 sessions of physical therapy in the past as well as an unknown number of aquatic therapy. Since there is an absence of documented frequency and duration of physical therapy, any significant improvement achieved by prior therapy, or weaning of treatment frequency, the request is not medically necessary according to the guidelines.