

Case Number:	CM14-0115641		
Date Assigned:	08/04/2014	Date of Injury:	01/29/2010
Decision Date:	09/15/2014	UR Denial Date:	07/10/2014
Priority:	Standard	Application Received:	07/22/2014

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 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 injured worker is a 37-year-old female who reported injury on 01/29/2010 caused by an unspecified mechanism. The injured worker's treatment history included medications and MRI. The injured worker was evaluated 07/16/2014 and it is documented that the injured worker complained of low back pain. The injured worker stated with the medication she was able to bring her pain down to a 5/10. On average, her pain can be up to 6/10 to 7/10, but at her worst, the pain can reach up to a 10/10. The injured worker states that with her medications she is able to light housework and walk for about half an hour, whereas without her medications she would not be able to do this. Objective findings: there were no significant changes. Medications included Norco 10/325 mg, ibuprofen 800 mg and BioFreeze gel. Diagnoses included right shoulder pain, thoracic spine pain, and low back pain. The Request for Authorization or rationale were not submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy 2x week 4 x week , right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder, physical therapy.

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

Decision rationale: The request is non-certified. The California MTUS Guidelines may support up to 10 visits of physical therapy for the treatment of unspecified myalgia and myositis to promote functional improvement. The documents submitted indicated the injured worker had an injury since 01/29/2010 however, the provider failed to indicate if the injured worker had any prior conservative care to include acupuncture sessions, chiropractic treatment and physical therapy. In addition, long-term functional goals were not provided for the injured worker. Given the above, the request for physical therapy 2 times a week for 4 weeks for right shoulders is non-certified.