

Case Number:	CM14-0157570		
Date Assigned:	09/30/2014	Date of Injury:	08/15/2013
Decision Date:	10/28/2014	UR Denial Date:	08/28/2014
Priority:	Standard	Application Received:	09/25/2014

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, has a subspecialty in Interventional Spine 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 52 year old male with an injury date on 08/15/2013. Based on the 07/18/2014 progress report provided by [REDACTED] the patient complains of ongoing low back pain radiating to the right lower extremity and right shoulder pain. Physical examination of the lumbar spine reveals a positive straight leg raise. Diagnosis 07/18/14:- Lumbar musculoligamentous sprain/strain with lower extremity radiculitis, rule out disc bulges, with slight facet degeneration, per radiographs.- Right shoulder sprain/strain, status post arthroscopy and rotator cuff, performed on 03/29/2014, with slight arcomioclavicular joint degeneration, per radiographs. The utilization review determination being challenged is dated 08/28/14. The rationale follows: 1. Physical therapy treatment and evaluation 3 times a week for 4 weeks for the lumbar spine Qty: 12. The utilization review denial letter states, "PT SOAP note date 10/17/2013 states that the claimant has completed 4 out of 6 authorized visit. The claimant feels about 90 to 95 percent better." 2. Physical therapy treatment and evaluation 3 times a week for 4 weeks for the right shoulder Qty: 12. The utilization review denial letter states, "There is limited information regarding the claimant's post-op clinical course of care including response to prior post-op physical therapy." [REDACTED] is the requesting provider, and he provided treatment reports from 05/05/2014 to 07/18/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy treatment and evaluation 3 times a week for 4 weeks, lumbar spine Qty: 12: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG-TWC)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines rotator cuff syndrome/impingement syndrome Page(s): 98-99.

Decision rationale: According to the 07/18/2014 report by [REDACTED], this patient presents with ongoing low back pain radiating to the right lower extremity and right shoulder pain. The physician is requesting physical therapy treatment and evaluation 3 times a week for 4 weeks for the lumbar spine Qty: 12. This request was modified to 3 times a week for 2 weeks by the 08/28/14 utilization review. The report with the request was not provided. The MTUS pages 98-99 have the following: "Physical Medicine: recommended as indicated below. Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." MTUS guidelines pages 98, 99 states that for "Myalgia and myositis, 9-10 visits are recommended over 8 weeks. For Neuralgia, neuritis, and radiculitis, 8-10 visits are recommended." Patient has post-laminectomy syndrome and presents with lumbar radiculopathy. In review of reports, there is no documentation of physical therapy treatments. The physician does not discuss why the patient needs physical therapy as this time. The request for 12 sessions exceeds what is allowed by MTUS. The request is not medically necessary.

Physical therapy treatment and evaluation, 3 times a week for 4 weeks, right shoulder Qty: 12: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG-TWC)

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: According to the 07/18/2014 report by [REDACTED], this patient presents with ongoing low back pain radiating to the right lower extremity and right shoulder pain. The physician is requesting for physical therapy treatment and evaluation 3 times a week for 4 weeks for the right shoulder Qty: 12. The report with the request was not provided. MTUS post-surgical guidelines for rotator cuff syndrome/impingement syndrome recommend 24 visits over 14 weeks. The report 07/18/2014 indicates patient diagnosed with status post arthroscopy and rotator cuff, performed on 03/29/2014. Review of the reports show no information regarding patient's post-op therapy treatments, as well as the number of physical therapy sessions completed to date. The physician does not discuss it and there were no therapy reports included in the file. It has been nearly 4 months following the patient's shoulder surgery and it is likely that the patient has had adequate post-operative therapy. The physician must keep track of the patient's progress per MTUS page 8. This request is not considered medically necessary.

