

Case Number:	CM14-0042210		
Date Assigned:	06/30/2014	Date of Injury:	11/26/2012
Decision Date:	09/16/2014	UR Denial Date:	04/01/2014
Priority:	Standard	Application Received:	04/09/2014

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 Preventive Medicine, has a subspecialty in Occupational Medicine and is licensed to practice in Iowa. 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:

This patient is a 61 year old employee with date of injury of 11/26/2012. Medical records indicate the patient is undergoing treatment for cervical radiculopathy, cervical pain, lumbar radiculopathy, shoulder pain and disc disorder lumbar and hip pain. Subjective complaints include neck pain, lower back ache, shoulder pain and right hip pain. His sleep quality is poor. Objective findings include: Cervical spine: Range of motion (ROM) is restricted with extension limited to 15 degrees limited by pain, lateral rotation to the left limited to 50 degrees and lateral rotation to the right limited to 50 degrees but flexion is normal. Spasm and tenderness is noted on both sides of his paravertebral muscles. Spurling's maneuver causes pain but no radicular symptoms. His biceps, triceps and brachioradialis reflex is 2/4 on both sides. On exam of the lumbar spine, there is loss of normal lordosis with straightening of the lumbar spine. ROM is restricted with flexion and limited to 50 degrees by pain, extension limited to 10 degrees by pain, lateral rotation to left to 20 degrees and lateral rotation to right 20 degrees. Spasm is noted on paravertebral muscles on both sides. The patient has positive lumbar facet loading on both sides. Straight leg raise is positive on both sides. The patellar jerk is 0/4 on both sides. His right hip joint reveals ROM is restricted with internal rotation limited to 20 degrees limited by pain and external rotation limited to 30 degrees. FABER test is positive. On examination, light touch sensation is decreased over C8 and T1 in left upper extremity L4 and L5 dermatomes on the left. Treatment has consisted of PT, 2 week trial of Duragesic patch, Celebrex, Neurontin, Norco, Trazodone and Lidoderm 5% patch. The utilization review determination was rendered on 4/01/2014 recommending non-certification of Additional Physical therapy 8 sessions left shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional Physical therapy 8 sessions left sholulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy, Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder (Acute & Chronic), Physical Therapy, ODG Preface - Physical Therapy.

Decision rationale: California MTUS guidelines refer to physical medicine guidelines for physical therapy. "Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." Regarding physical therapy, ODG states "Patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy); & (6) When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted." At the conclusion of this trial, additional treatment would be assessed based upon documented objective, functional improvement, and appropriate goals for the additional treatment. The treating physician has not provided medical documentation of functional improvement from previous therapy. In addition, the treating physician has not provided medical documentation of physical therapy that cannot be addressed by a home exercise program. As such, the request for Additional Physical therapy 8 sessions left shoulder is not medically necessary.