

Case Number:	CM14-0047530		
Date Assigned:	09/05/2014	Date of Injury:	05/10/2013
Decision Date:	10/09/2014	UR Denial Date:	04/15/2014
Priority:	Standard	Application Received:	04/16/2014

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 Emergency Medicine and is licensed to practice in Texas. 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 56-year-old male who reported injury on 05/10/2013. The mechanism of injury was not provided. The medications and prior diagnostic studies were not provided. The prior therapies include physical therapy, shoulder injections, and a right knee injection. The documentation of 03/24/2014 revealed the injured worker had low back pain, right knee pain, and left shoulder pain. The injured worker had a positive Neer sign and crank sign with internal rotation on the left shoulder. The injured worker had moderate tenderness with spasticity over the left L4-L5 and L5-S1 levels and left greater trochanteric bursa region. The range of motion was complete in all directions with moderate pain upon extension and slight pain upon right lateral flexion pulling on the left. The motor strength was 5/5 and the sensibility was intact. The diagnoses included left acromioclavicular impingement, left rotator cuff syndrome, left medial meniscal injury, left L4-L5 and L5-S1 flexion, rotation and side bending strain, left sacroiliac arthralgia, and left lumbar radiculitis. The treatment plan included a request for physical therapy to continue. There was a Request for Authorization submitted for review dated 03/24/2014 which was for 6 sessions of physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional physical therapy to treat the left shoulder and back: Upheld

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

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

Decision rationale: The California MTUS Guidelines recommend physical therapy for myalgia and myositis for 9 to 10 sessions. The clinical documentation submitted for review failed to indicate the quantity of sessions previously attended. There was a lack of documentation indicating the objective functional benefit that was received from prior therapy. There was a lack of documentation indicating the injured worker had objective functional deficits to support the necessity for continued supervised therapy. The request as submitted failed to indicate the quantity of sessions being requested. Given the above, the request for additional physical therapy to treat the left shoulder and back is not medically necessary.