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| Case Number: | CM14-0067300 | | |
| Date Assigned: | 07/11/2014 | Date of Injury: | 03/18/2013 |
| Decision Date: | 09/12/2014 | UR Denial Date: | 04/08/2014 |
| Priority: | Standard | Application Received: | 05/12/2014 |

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 Illinois. 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 35-year-old male who reported an injury on 03/18/2013. The mechanism of injury was not provided. On 06/16/2014, the injured worker presented with left shoulder pain. Upon examination, cervical spine range of motion was accomplished without the injured worker expressing any complaints of pain during maneuvers. There was no evidence of radiating pain to the upper extremities and there was a negative Spurling's and compression test. Range of motion values to the left shoulder revealed 150 degrees of flexion, 150 abduction, 80 degrees of external rotation, and 70 internal rotation. There was 5/5 strength and a positive impingement to the left shoulder. The diagnosis was impingement to the left shoulder. The provider recommended 6 sessions of physical therapy 3 times a week for 2 weeks for the lumbar spine. The provider's rationale was not provided. The Request for Authorization form was not included in the medical documents for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

6 Sessions of Physical Therapy 3 times a week for 2 weeks for the Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Low Back; Physical Therapy Guidelines - Lumbago, Backache.

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

Decision rationale: The California MTUS state that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. Injured workers are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. There was lack of documentation indicating the injured worker's prior course of physical therapy, as well as the efficacy of the prior therapy. The guidelines recommend 10 visits of physical therapy; the amount of physical therapy visits that have already been completed were not provided. Additionally, there were no specific deficits addressed in the lumbar spine area. Injured workers are instructed and expected to continue aquatic therapies at home and there are no significant barriers to transitioning the injured worker to an independent home exercise program. As such, the request is not medically necessary.