

Case Number:	CM14-0088797		
Date Assigned:	07/25/2014	Date of Injury:	03/24/2011
Decision Date:	08/28/2014	UR Denial Date:	05/16/2014
Priority:	Standard	Application Received:	06/12/2014

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 Pain Management, 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 42 year old with an injury date on 3/24/11. Patient complains of improving left upper extremity pain, improving left lower extremity pain, and ongoing left shoulder/left knee/neck pain per 4/25/14 report. Patient has general pain and numbness down her bilateral legs per 4/25/14 report. Based on the 4/25/14 progress report provided by [REDACTED] the diagnoses are: 1. left shoulder rotator cuff tear 2. left knee pain 3. left chondromalacia patella 4. cervicalgia 5. left arm radiculopathy 6. left elbow medial epicondylitis 7. left elbow lateral epicondylitis 8. left hip greater trochanteric bursitis 9. left leg radiculopathy Exam on 4/25/14 showed "left shoulder: full range of motion. Left elbow: full range of motion. Left hip: Abduction to 45 degrees, adduction to 25 degrees, flexion to 135 degrees. Left knee: range of motion: 0-135. L-spine: positive straight leg raise on left. C-spine: moderately limited by 50% except forward flexion which is normal." [REDACTED] is requesting physical therapy re-evaluation of left upper extremity, left lower extremity, cervical, and lower back, and physical therapy 3 times a week to left upper extremity, left lower extremity, cervical, and lower back. The utilization review determination being challenged is dated 5/16/14. [REDACTED] is the requesting provider, and he provided treatment reports from 11/26/13 to 6/9/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy re-evaluation of left upper extremity, left lower extremity, cervical and low back: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 92,Chronic Pain Treatment Guidelines Functional Restoration Page(s): 7.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG: Codes for Automated Approval.

Decision rationale: This patient presents with left arm/shoulder/elbow pain, left hip/leg/knee pain, and neck pain. The treating physician has asked for physical therapy re-evaluation of left upper extremity, left lower extremity, cervical, and lower back on 4/25/14. MTUS and ODG are silent regarding physical therapy re-evaluations. For the following 10 diagnoses, ODG pain chapter allows the automatic approval of a physical therapy evaluation: Reflex sympathetic dystrophy, Complex regional pain syndrome (CRPS I), Pain not elsewhere classified, Chronic pain, Chronic pain syndrome, Causalgia of upper limb, Complex regional pain syndrome (CRPS II), Causalgia of lower limb, (CRPS-II), Mononeuritis of unspecified site, (CRPS-II), and Myalgia and myositis, unspecified. In this case, the treater has asked for physical therapy re-evaluation but has not included a useful discussion regarding the request. As patient does not present with any of the diagnoses which ODG lists for automatic approval for physical therapy evaluation, the current request for re-evaluation would not be considered medically necessary at this time. The request is not medically necessary and appropriate.

Additional Physical therapy 3 times a week to left upper lower extremities, cervical and low back: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MTUS pg. 98, 99: Passive therapy Page(s): 98-99.

Decision rationale: This patient presents with left arm/shoulder/elbow pain, left hip/leg/knee pain, and neck pain. The treating physician has asked for physical therapy 3 times a week to left upper extremity, left lower extremity, cervical, and lower back on 4/25/14 and request for authorization of same date clarifies request: "additional 12." Review of the physical therapy shows patient had 9 sessions from 3/28/14 to 4/23/14. The treating physician states previous physical therapy sessions have been divided amongst multiple body parts, and an additional 12 are requested to continue treatment per 4/25/14 report. MTUS guidelines allows for 8-10 sessions of physical therapy for various myalgias and neuralgias. When combined with previous 9 sessions, the current request for 12 physical therapy visits would exceed MTUS guidelines for this type of condition. The documentation does not state the necessity for additional therapy, with no recent flare-up, functional decline, new injury, etc, that would warrant another course of therapy. The request is not medically necessary and appropriate.