

Case Number:	CM14-0120965		
Date Assigned:	08/06/2014	Date of Injury:	08/15/2005
Decision Date:	04/02/2015	UR Denial Date:	07/21/2014
Priority:	Standard	Application Received:	07/31/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Illinois, California, Texas
 Certification(s)/Specialty: Orthopedic Surgery

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 43-year-old male, who sustained an industrial injury on 8/15/05. The 6/6/15 lumbar spine MRI revealed mild central canal stenosis at T11-12 due to a broad-based disc protrusion/extrusion. There was a grade 1 anterolisthesis of L3 on L4 and a posterior disc protrusion at L4/5 causing mild pressure on the thecal sac. There was a mild left paracentral disc protrusion at L5/S1. The 9/12/13 electrodiagnostic studies documented right L5 radiculopathy. The patient underwent right shoulder arthroscopy with rotator cuff repair, decompression, acromioplasty and debridement on 6/28/13, followed by 24 post-op physical therapy visits. The 6/24/14 treating physician report indicated the patient had neck, upper and lower back, and bilateral shoulder, elbow, and knee pain, with no new numbness and tingling. Physical exam documented sensation was intact. The diagnoses included cervical spine disc bulges, thoracic spine strain, lumbar spine disc extrusion with radiculopathy, status post bilateral shoulder surgery, bilateral elbow. As the surgical request is not supported, this request is not medically necessary, and right knee internal derangement, status post surgery. The treatment plan recommended physical therapy 2x6 for the right shoulder and cervical, thoracic, and lumbar spine. Consultations with internal medicine, orthopedics, pain medicine, and ENT. The patient had not been working and was off for 6 weeks. On 7/21/14 Utilization Review non-certified a request for physical therapy, 2 times a week for 6 weeks, to the right shoulder, cervical spine, thoracic spine and lumbar spine, noting the (MTUS) Medical Treatment Utilization Schedule guideline chronic pain physical medicine Arthroscopy of the right shoulder with rotator cuff repair, decompression, acromioplasty, and debridement was cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post-op physical therapy, 2x6, to the right shoulder, cervical spine, thoracic spine and lumbar spine.: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Introduction, Physical Medicine Page(s): 9, 98-99.

Decision rationale: California MTUS Post-Surgical Treatment Guidelines do not apply to this case as the 6-month post-surgical treatment period had expired relative to the right shoulder. The California MTUS guidelines recommend therapies focused on the goal of functional restoration rather than merely the elimination of pain. The physical therapy guidelines state that patients are expected to continue active therapies at home as an extension of treatment and to maintain improvement. Guideline criteria have not been met. There is no documentation of functional treatment goals for the requested physical therapy. There is no functional assessment or specific functional deficit identified. Clinical exam findings were limited to sensory exam. There were no range of motion, strength, or neurologic deficits documented. There is no compelling reason to support the medical necessity of supervised physical therapy in this 2005 injury, over an independent home exercise program. Therefore, this request is not medically necessary.