

Case Number:	CM14-0136858		
Date Assigned:	09/03/2014	Date of Injury:	11/19/2012
Decision Date:	03/16/2015	UR Denial Date:	07/29/2014
Priority:	Standard	Application Received:	08/25/2014

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: California, Washington

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 61-year-old male who reported an injury on 11/19/2012. The mechanism of injury reportedly occurred when a pallet fell onto his left shoulder. His diagnoses included pain in the joint of the left leg and lumbar sprain. His past treatments have included medications and physical therapy for the right shoulder. Diagnostic studies included MRIs of the neck, lower back, left knee, left shoulder, and a nerve study of the upper extremities. His past surgical history includes a right shoulder arthroscopic subacromial decompression with Mumford debridement of labral tear on 04/07/2014. The injured worker presented on 01/14/2015 with complaints of neck, upper and lower back, bilateral shoulder, and left knee pain. The injured worker rated his neck pain 2-3/10 that can increase to 5-7/10 with any kind of movement. He further stated that the pain radiates to his shoulders, arms, and fingers and to the upper back with occasional tingling and pain in his hands and fingers with numbness in the hands. In regard to his upper and lower back, the injured worker complained of a frequent 3/10 level pain in his upper back; the lower back pain radiates to his left foot. The injured worker rated his right shoulder pain at a constant 3/10 level that radiates into the neck. He further stated if he uses his arm, this increase the pain to at least a 5/10. The injured worker rated his left shoulder pain a 3/10 with increasing pain to 6/10 to 7/10 with activities such as showering and changing clothes. The injured worker rated his left knee pain a constant 2/10 to 3/10 in the medial patella that can increased to a 5/10 with climbing the stairs and occasional limping in the morning. He denied any giving way of his left knee or locking. Upon physical examination, cervical flexion was at 45 degrees, extension was at 45 degrees, and rotation was at 75 degrees bilaterally. Active

shoulder abduction was at 165 degrees bilaterally. Forward flexion was at 175 degrees bilaterally. Extension was at 30 degrees, adduction was at 40 degrees bilaterally, passive abduction of the glenohumeral joint with the scapula held fixed was at 90 degrees bilaterally, external rotation in maximum adduction was at 90 degrees bilaterally and internal rotation in maximum abduction was at 50 degrees right and 65 degrees left. The injured worker had pain over the right anterior humerus. The injured worker had a palpable biceps tendon within the bicipital groove which was very tender; he had pain with shoulder range of motion at the biceps tendon, and a Popeye muscle which would be consistent with a ruptured biceps tendon that is still entrapped in the bicipital groove. Upon physical examination of the left shoulder, the injured worker had anterior glenohumeral tenderness and left shoulder tenderness. Bilaterally, he had pain with impingement maneuvers on the right at the bicipital groove. Upon evaluation of the back and lower extremities, the injured worker had a normal gait. He was able to toe and heel walk. Forward bend was at 60 degrees. Sitting straight leg raise was negative. Upon physical evaluation of the knees, the injured worker demonstrated full range of motion, 0 to 130 degrees bilaterally. He had minimal medial joint line tenderness. No lateral or patellofemoral tenderness was noted, McMurray's test caused minimal pain, Lachman's test was negative, and varus/valgus was stable. His relevant medications included Motrin 350 mg since at least 04/07/2014. The treatment plan included a biceps tendon sheath release followed by subpectoral biceps tenodesis, a review of the previous left shoulder MRI, a copy of the report from a lumbar spine MRI, a Request for Authorization for a left knee injection and x-rays, and work restrictions including no repetitive over shoulder work with no lifting more than 10 pounds. The rationale for the request was not provided. A Request for Authorization form for the submitted request was not provided within the documentation submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

CONTINUED PHYSICAL THERAPY (NO FREQUENCY OR DURATION GIVEN):

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 request for continued physical therapy (no frequency or duration given) is not medically necessary. The injured worker has low back, shoulder, and knee pain. California MTUS Treatment Guidelines recommend physical therapy and 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. Additionally, the guidelines state patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. The documentation submitted for review fails to provide evidence of objective functional improvement from previous physical therapy for the same body part or condition. Additionally, the request as submitted does not indicate what body part physical therapy is requested for. Furthermore, there

are no exceptional factors to justify additional supervised visits over a home exercise program. As such, the request for continued physical therapy (no frequency or duration given) is not medically necessary.