

Case Number:	CM14-0191852		
Date Assigned:	11/25/2014	Date of Injury:	05/25/2012
Decision Date:	03/05/2015	UR Denial Date:	10/28/2014
Priority:	Standard	Application Received:	11/17/2014

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: Texas, California

Certification(s)/Specialty: Family Practice

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 48 year old male who experienced a work injury dated 05/25/2012. He states he was walking when he stepped on an orange peel with his right foot causing him to fall back. He put his right hand out to break his fall landing on his buttock, right side of the upper back, lower back, right shoulder and right arm. Approximately 5 days later he began to have pain in his right shoulder and right arm. X-rays were obtained and he was treated with medication, physical therapy and bracing. He was placed on modified duty. The injured worker stated pain continued and increased. He went to see his personal physician in March 2013 and was treated with medication and was not sent back to work. Prior treatment consisted of chiropractic care, physical therapy, extracorporeal shock wave treatments and subacromial injection to right shoulder. He stated there was some improvement in his condition. He was offered the option of shoulder surgery which he declined due to improvement with physical therapy. On 04/24/2013 the treating physician recommended chiropractic care, MRI of right shoulder, lumbar spine and cervical spine as well as lower extremity electro diagnostic testing. He was also referred for pain management and evaluation for erectile dysfunction. Electro diagnostic study of the upper extremities on 05/16/2013 revealed findings consistent with moderate left cervical (C) 7 and severe right C 5 radiculopathy. MRI of the cervical spine, lumbar spine and right shoulder dated 07/09/2014 are available in the submitted records. Physical therapy visits are also available in the submitted records. On 10/08/2014 the IW was complaining of neck, upper and lower back pain and right shoulder pain. Diagnoses included: - Cervical spine disc bulge - Thoracic spine strain - Lumbar spine disc rupture with radiculopathy - Right shoulder internal

derangement. The patient has had an extended course of physical therapy totaling 40 authorized visits. Physical examination revealed normal sensory examination.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy 2xWk x 6Wks for Cervical, Thoracic, Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck & Upper Back, Low Back - Lumbar & Thoracic (Acute & Chronic), Physical Therapy (PT)

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

Decision rationale: Request: Physical Therapy 2xWk x 6Wks for Cervical, Thoracic, Lumbar Spine. The guidelines cited below state, allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home physical medicine. The patient has had an extended course of physical therapy totaling 40 authorized visits. Previous conservative therapy notes were not specified in the records provided. The requested additional visits in addition to the previously certified PT sessions are more than recommended by the cited criteria. The records submitted contain no accompanying current PT evaluation for this patient. There was no evidence of ongoing significant progressive functional improvement from the previous PT visits that is documented in the records provided. A recent detailed clinical evaluation note of treating physician was not specified in the records. A detailed physical examination was not specified in the records provided. There was no objective documented evidence of any significant functional deficits that could be benefitted with additional PT. Per the guidelines cited, "Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels." A valid rationale as to why remaining rehabilitation cannot be accomplished in the context of an independent exercise program is not specified in the records provided. The medical necessity of the request for Physical Therapy 2xWk x 6Wks for Cervical, Thoracic, Lumbar Spine is not fully established for this patient.