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| Case Number: | CM14-0203774 | | |
| Date Assigned: | 12/16/2014 | Date of Injury: | 07/03/2014 |
| Decision Date: | 02/06/2015 | UR Denial Date: | 11/20/2014 |
| Priority: | Standard | Application Received: | 12/05/2014 |

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 Rehab, has a subspecialty in Pain Medicine 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:

This is a 45-year-old male with a work-related injury dated July 3, 2014. The injury was described as pallets falling on him while he was walking and hitting his right hand, shoulder and back. Pain was described in the right hip and right back and was rated eight on a scale of ten. The physician's documentation dated October 28, 2014 reflected that the worker was having increased pain with activities. Pain was located in the low back, neck, middle back and shoulder. To date the worker had received nine sessions of physical therapy with three remaining of twelve visits. Subjective complaints indicate that the cervical and thoracic spine are unchanged and the right shoulder is unchanged. Physical examination findings revealed tenderness to palpation in the low back with 5/5 strength in the lower extremities with the exception of the hip on the left side and extensor hallucis longus on the left side which are 4/5. The physician was requesting an additional eight physical therapy visits. Diagnoses at this visit included lumbosacral, thoracic and cervical spine myospasm and myalgia. Medications at this visit included cyclobenzaprine, naproxen and pantoprazole. The utilization review decision dated November 18, 2014 non-certified the request for eight additional physical therapy visits for the right shoulder, cervical spine, thoracic spine, and lumbar Spine two times per week for four weeks. The rationale for non-coverage was the CA MTUS, which states that physical therapy in the chronic phase of treatment which allows for fading of treatment frequency from up to three visits to one or less per week. The guidelines also state that patients are instructed and expected to continue active therapy at home as an extension of the treatment process. The documentation reviewed did not reflect any remaining functional deficits that would warrant the continuing of physical therapy beyond the recommendation guidelines. The additional eight visits were denied as not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

8 Additional Physical Therapy Sessions for The Right Shoulder, Cervical Spine, Thoracic Spine, and Lumbar Spine, 2 Times Per Week for 4 Weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints, Chapter 12 Low Back Complaints Page(s): 173; 200; 298, Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 98 OF 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Physical Therapy, Neck & Upper Back Chapter, Physical Therapy, Low Back Chapter, Physical Therapy.

Decision rationale: Regarding the request for additional physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. The ODG has more specific criteria for the ongoing use of physical therapy. The ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Chronic Pain Medical Treatment Guidelines recommend 9-10 visits of therapy for the diagnosis of myalgia/myositis. The ODG recommends a maximum of 10 visits for the treatment of lumbar strains, cervical strains, and rotator cuff disorders. Within the documentation available for review, there is documentation of completion of prior PT sessions, but there is no documentation of specific objective functional improvement (in all treated body parts) and remaining deficits (in all body parts) that cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised therapy. Furthermore, when added to the number of previous visits, the request exceeds the amount of PT recommended by the CA MTUS/ODG and, unfortunately, there is no provision for modification of the current request. In light of the above issues, the currently requested additional physical therapy is not medically necessary.