

Case Number:	CM15-0006449		
Date Assigned:	01/29/2015	Date of Injury:	10/07/2011
Decision Date:	03/20/2015	UR Denial Date:	12/31/2014
Priority:	Standard	Application Received:	01/12/2015

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

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 (IW) is a 63 year old male, who sustained industrial injuries on October 5, 2010 and October 7, 2011. He has reported neck, upper extremities, bilateral shoulders, arms, hands, the back and stomach pain and was diagnosed with status post right shoulder arthroscopic subacromial decompression and partial distal claviclectomy and right lumbar 4-5 and lumbar 5 through sacral 1 neural foraminal stenosis secondary to lumbar 4-5 and lumbar 50-sacral; 1 disc protrusions. Treatment to date has included radiographic imaging, diagnostic procedures, surgical interventions, pain medications and work restrictions. Currently, the IW complains of neck, upper extremities, bilateral shoulders, arms, hands, the back and stomach pain. The injured worker reported an industrial injury in 2011. Since the injury he has had continued pain. It was noted he tried many failed conservative therapies and has undergone surgical intervention. On September 24, 2014, evaluation revealed continued back pain. It was noted further surgical need was unlikely. On December 31, 2014, Utilization Review non-certified a request for physical therapy three times weekly for four weeks for the lumbar, right shoulder and cervical spine, noting the MTUS, ACOEM Guidelines, (or ODG) was cited. On January 12, 2015, the injured worker submitted an application for IMR for review of requested physical therapy three times weekly for four weeks for the lumbar, right shoulder and cervical spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy 3x4, lumbar spine and cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines, 11 edition, 2014, Shoulder, Physical Therapy

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

Decision rationale: Based on the 12/01/14 progress report provided by treating physician, the patient presents with low back pain with extremity symptoms rated 6/10, cervical pain with upper extremity symptoms rated 5/10 and right shoulder pain rated 7/10. The request is for physical therapy 3x4, lumbar spine and cervical spine. The patient is status post right shoulder arthroscopic subacromial decompression, date unspecified. Patient's diagnosis per Request for Authorization form dated 12/23/14 included protrusion L4-5 and L5-S1 with foraminal narrowing and radiculopathy. Patient's medications include Tramadol, Cyclobenzaprine, Naproxen sodium and Pantoprazole. The patient is permanent and stationary. MTUS Chronic Pain Management Guidelines, pages 98, 99 has the following: "Physical Medicine: recommended as indicated below. Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." MTUS guidelines pages 98, 99 states that for "Myalgia and myositis, 9-10 visits are recommended over 8 weeks. For Neuralgia, neuritis, and radiculitis, 8-10 visits are recommended." Per progress report dated 12/01/14, treater states "continue with request for physical therapy right shoulder, lumbar spine, cervical spine at 3 times per week for 4 weeks." Treater has not provided reason for the request. Given patient's diagnosis, a short course of physical therapy would be indicated. However, there is no treatment history available, nor documentation of efficacy of prior treatment. Treater does not discuss any flare-ups, explain why on-going therapy is needed, or reason the patient is unable to transition into a home exercise program. Furthermore, the request for 12 sessions would exceed guideline recommendation for the patient's condition. Therefore, the request is not medically necessary.