

Case Number:	CM15-0009322		
Date Assigned:	01/27/2015	Date of Injury:	10/04/2013
Decision Date:	03/20/2015	UR Denial Date:	01/07/2015
Priority:	Standard	Application Received:	01/15/2015

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 is a 35 year old, who sustained an industrial injury on 10/4/2013. The initial injury was documented to have reported right shoulder and left knee pain. Magnetic Resonance Imaging (MRI) of the right knee, lumbar spine, and right shoulder completed on 9/26/14 was significant for medial meniscus tear, medial collateral sprain, patellar tendinitis, and bursitis, lumbar desiccation of discs with protrusion on multiple levels, and annular tear, rotator cuff tear. The diagnoses have included. Documentation of the treatment to date was not submitted for this review. Currently, the IW complains of constant severe right shoulder pain radiating to mid arm associated with numbness, weakness and cramping, and intermittent left knee pain, numbness and weakness. Diagnoses included rotator cuff tear, right shoulder bursitis, right deltoid tear, and left knee sprain/strain and left knee contusion. Plan of care included chiropractic treatment, physiotherapy, kinetic activities and modified activity. On 1/7/2015 Utilization Review non-certified additional physical therapy two to three (2-3) times week for six (6) weeks, noting the medical records submitted did not support functional improvement with prior physical therapy treatment per regulations. The MTUS Guidelines were cited. On 1/15/2015, the injured worker submitted an application for IMR for review of additional physical therapy two to three (2-3) times week for six (6) weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Continued physical therapy: 2-3 times a week times 6 weeks: 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 patient was injured on 10/04/13 and presents with left knee pain and right shoulder pain which radiates to his mid arm and shoulder blade. The request is for CONTINUED PHYSICAL THERAPY 2-3 TIMES A WEEK TIMES 6 WEEKS. There is no RFA provided and the patient is on a modified work duty which includes no reaching above shoulder level, no prolonged walking/standing, avoid repetitive kneeling/squatting, no prolonged kneeling/squatting, avoid heavy push/pulling with right arm and no heavy lifting with right arm. The report with the request is not provided. It appears that the patient has had prior physical therapy. MTUS page 98 and 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 page 98 and 99 states that for myalgia and myositis, 9 to 10 visits are recommended over 8 weeks, and for neuralgia, neuritis, and radiculitis, 8 to 10 visits are recommended. Review of the reports provided does not indicate if the patient has had any recent surgery. Although the patient has had prior physical therapy sessions, there is no indication of when these sessions took place, how many sessions the patient had, or how these sessions impacted the patient's pain and function. There is no discussion as to why the patient is not able to establish a home exercise program to manage pain. Furthermore, the treater is requesting for 12-18 sessions of physical therapy, which exceeds what is allowed by MTUS Guidelines. The requested physical therapy IS NOT medically necessary.

Soma 350mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for Pain); Carisoprodol (Soma).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63-66.

Decision rationale: The patient was injured on 10/04/13 and presents with left knee pain and right shoulder pain which radiates to his mid arm and shoulder blade. The request is for SOMA 350 MG (no quantity provided). There is no RFA provided and the patient is on a modified work duty which includes no reaching above shoulder level, no prolonged walking/standing, avoid repetitive kneeling/squatting, no prolonged kneeling/squatting, avoid heavy push/pulling with right arm and no heavy lifting with right arm. The report with the request is not provided and there is no indication of when the patient began taking this medication. MTUS Chronic Pain Medications Guideline muscle relaxants, page 63-66, "Carisoprodol (Soma); neither of these formulations is recommended for longer than a 2 to 3 week period." This has been noted for

sedative and relaxant effects. The patient has +3 tenderness to palpation of the anterior/posterior shoulder, a decreased/painful right shoulder range of motion, a painful Hawkins's, a painful Yergason's, a painful supraspinatus press, +3 tenderness to palpation of the medial knee and superior border of patella, a decreased and painful range of motion for the left knee, a painful Valgus test, and a painful Varus test. In this case, the treater does not indicate if this medication is for short-term use. Long-term use of this medication is not supported by MTUS Guidelines. It is unknown when the patient began taking this medication and he may have already exceeded the 2 to 3 weeks period recommended by MTUS guidelines. Therefore, the requested Soma IS NOT medically necessary.