

Case Number:	CM15-0137784		
Date Assigned:	07/27/2015	Date of Injury:	04/27/2015
Decision Date:	08/24/2015	UR Denial Date:	07/07/2015
Priority:	Standard	Application Received:	07/16/2015

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, 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:

This 51 year old man sustained an industrial injury on 4/27/2015. The mechanism of injury is not detailed. Evaluations include chest x-rays dated 4/27/2015, lumbar spine x-rays dated 4/27/2015, right shoulder x-rays dated 4/27/2015, and cervical spine CT scan dated 4/27/2015. Diagnoses include acromioclavicular sprain, right biceps tendonitis, right rotator cuff sprain, left distal radius fracture, left wrist tendonitis, lumbar strain, and lumbar radicular pain. Treatment has included oral medications and physical therapy. Physician notes dated 6/25/2015 show complaints of right shoulder pain rated 6-8/10, low back pain rated 7-8/10 with radiation to the bilateral lower extremities, left shoulder pain rated 4-5/10, and left hand pain rated 4-5/10. Recommendations include physical therapy and right shoulder MRI, and follow up in two weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

6 Physical therapy visits between 7/1/15 and 8/15/15: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Physical Therapy Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 200. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder 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. ODG has more specific criteria for the ongoing use of physical therapy. 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. 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 with the previous sessions and remaining deficits that cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised therapy. Furthermore, it is unclear which body part is intended to be addressed with the currently requested therapy. In light of the above issues, the currently requested additional physical therapy is not medically necessary.