

Case Number:	CM15-0139761		
Date Assigned:	07/29/2015	Date of Injury:	02/29/1996
Decision Date:	08/27/2015	UR Denial Date:	07/01/2015
Priority:	Standard	Application Received:	07/20/2015

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:

The injured worker is a 68 year old female who sustained an industrial/work injury on 2-29-96. She reported an initial complaint of back, right hip, and right leg pain. The injured worker was diagnosed as having cervicgia, chronic major depression-stable, thoracic outlet syndrome s/p rib resection. Treatment to date includes medication and diagnostics. MRI results were reported on 9-30-14. X-ray results were reviewed on 5-8-15 that noted AC (acromioclavicular) joint degenerative changes, subacromial osteophytes. Assessment reported osteoarthritis of right acromioclavicular joint, right bicipital tendonitis, and subacromial bursitis on the right with impingement. Currently, the injured worker complained of pain in the right side of the back, right hip, and back of the right leg and front of the thigh. Per the primary physician's report (PR-2) on 5-8-15, exam noted active abduction gives pain at 50 degrees, active forward flexion gives pain at 60 degrees, and no decreased response to tactile stimulation in the right arm, strength is reduced in the right arm, normal reflexes. Current plan of care included ice to the right shoulder, physical therapy, and follow up. The requested treatments include physical therapy, right shoulder, and low back.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy, Right Shoulder, Low Back, 8 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99.

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

Decision rationale: In the case of this injured worker, the submitted documentation failed to indicate functional improvement from previous physical therapy. This functional improvement can include a reduction in work restrictions or other clinically significant improved function in activities of daily living. According to the Chronic Pain Medical Treatment Guidelines, continuation of physical therapy is contingent on demonstration of functional improvement from previous physical therapy. There is no comprehensive summary of how many sessions have been attended in total over the course of this injury, and what functional benefit the worker gained from PT. This is especially important in cases where the original date of injury was remote. Therefore additional physical therapy is not medically necessary.