MAXIMUS Federal Services

Case Number:	CM15-0191923		
Date Assigned:	10/05/2015	Date of Injury:	01/27/2012
Decision Date:	11/12/2015	UR Denial Date:	08/27/2015
Priority:	Standard	Application Received:	09/29/2015

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 61 year old male who sustained an industrial injury on 1-27-12. A review of the medical records indicates he is undergoing treatment for cervical spine multilevel spondyloses at C3-C4, C4-C5, and C6-C7, right shoulder strain; status post rotator cuff repair in 2005, right hip greater trochanteric bursitis; status post injection; improved, lumbar spine L3- L4 4 millimeter disc, L4-L5 4 millimeter disc causing neural foraminal stenosis, chronic left elbow epicondylitis and cubital tunnel syndrome ; status post cubital tunnel release and ulnar nerve transposition in 2005-2006, left shoulder impingement with left shoulder rotator cuff repair in 2005 or 2006, right knee contusion, and chronic sprain of bilateral ankles; status-post surgery. Medical records (2-20-15 to 8-11-15) indicate ongoing complaints of neck, shoulder, low back, and bilateral ankle pain. On average, his pain rating with use of medications, has been "2-3 out of 10" and "5-6 out of 10" without medications. However, on 7-14-15, he rated his pain "5 out of 10" with medications and "9 out of 10" without medications. He indicated that he was "out" of his Norco at that time. He describes his pain as "sharp and stabbing", but indicates that it "fluctuates". The physical exam (8-11-15) reveals "decreased range of motion". The treating provider states that he has spasm of the cervical spine and lumbar spine, as well as "pain over the area". No "evidence of radiculopathy" is noted. "Significant" pain is noted with lateral bending of the lumbar spine and with bending forward. "Paraspinal muscle spasm" is noted in the neck and back areas. The treating provider indicates that his "range of motion is decreased by 30% compared to before because of this pain". Diagnostic studies have included urine drug screening,

an MRI of the cervical spine and lumbar spine, and an MRI arthrogram of the right shoulder. EMG-NCV of the bilateral upper extremities was recommended. However, it is unclear if this was completed. Treatment has included medications, a TENS unit, low-impact aerobic exercise, and physical therapy. The progress record from 2-20-15 indicates that the injured worker was "unable to fully participate due to pain" in regards to physical therapy. The number of sessions completed is not indicated in the provided records. The injured worker's work status is not indicated in the provided records of 8-11-15. The effects of his symptoms on activities of daily living are not indicated in the provided records. The treatment plan includes physical therapy two times a week for six weeks. The utilization review (8-27-15) indicates modification of the request to 8 sessions.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy 2 times a week for 6 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

Decision rationale: Review indicates the request for PT was modified for 8 sessions. Time-limited care plan with specific defined goals, assessment of functional benefit with modification of ongoing treatment based upon the patient's progress in meeting those goals and the provider's continued monitoring of successful outcome is stressed by MTUS guidelines. Therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. Submitted reports have no acute flare-up or specific physical limitations to support for physical/ occupational therapy. The Chronic Pain Guidelines allow for 9-10 visits of therapy with fading of treatment to an independent self-directed home program. It is unclear how many PT sessions have been completed; however, the submitted reports have not identified clear specific functional improvement in ADLs, functional status, or decrease in medication and medical utilization nor have there been a change in neurological compromise or red-flag findings demonstrated from the formal physical therapy already rendered to support further treatment. Submitted reports have also not adequately demonstrated the indication to support for excessive quantity of PT sessions without extenuating circumstances established beyond the guidelines. The Physical Therapy 2 times a week for 6 weeks is not medically necessary and appropriate.