MAXIMUS Federal Services

Case Number:	CM15-0203955		
Date Assigned:	10/20/2015	Date of Injury:	12/21/2010
Decision Date:	12/02/2015	UR Denial Date:	10/07/2015
Priority:	Standard	Application Received:	10/16/2015

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: Maryland
Certification(s)/Specialty: Physical Medicine & Rehabilitation, Neuromuscular Medicine

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 67 year old male, who sustained an industrial injury on 12-21-10. The injured worker has complaints of bilateral shoulders, left ankle and right knee pain. There is upper arm tenderness about the left shoulder as well as weakness and mild swelling. Bilateral shoulder and bilateral humerus X-rays showed no increase of osteoarthritis. Right knee and right tibia X-rays show increase of osteoarthritis. Left foot X-ray and left ankle X-rays show an increase of osteoarthritis. Magnetic resonance imaging (MRI) left shoulder on 3-31-15 revealed there is mild subscapularis tendinosis; there is also linear intrasubstance meniscal tearing of infraspinatus tendon series 5 image 5 out of 18 and no definite full-thickness tear. The diagnoses have included lumbar spine disc herniation, bilateral shoulder impingement. Treatment to date has included left shoulder arthroscopy. Per documentation the patient was authorized 24 sessions of PT for the right shoulder after surgery in February 2014 and authorized 24 sessions of post operative PT for the left shoulder. The original utilization review (10-7-15) non-certified the request for physical therapy 3 times a week for 4 weeks for the lumbar spine and bilateral shoulders and interferential unit and supplies 30-60 day rental and purchase for the lumbar spine and bilateral shoulders.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy 3 times a week for 4 weeks for the lumbar spine and bilateral shoulders: 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, and Postsurgical Treatment 2009, Section(s): Shoulder.

Decision rationale: Physical Therapy 3 times a week for 4 weeks for the lumbar spine and bilateral shoulders is not medically necessary per the MTUS Guidelines. The MTUS recommends a transitioning from supervised PT to an independent home exercise program. The documentation indicates that the patient has had appropriate postoperative shoulder PT. At this point the patient should be well versed in a home exercise program. The MTUS recommends up to 10 visits of PT for the lumbar spine. The request exceeds this number of recommended visits. The documentation does not reveal extenuating factors which necessitate 12 sessions of supervised PT for the bilateral shoulders and lumbar spine.

Interferential Unit and supplies 30-60 day rental and purchase for the Lumbar Spine and Bilateral Shoulders: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

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

Decision rationale: Interferential Unit and supplies 30-60 day rental and purchase for the lumbar spine and bilateral s shoulders purchase is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines state that the interferential unit is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. Additionally, the MTUS guidelines states that an interferential unit requires a one-month trial to permit the physician and physical medicine provider to study the effects and benefits. There should be evidence of increased functional improvement, less reported pain and evidence of medication reduction. The documentation does not reveal evidence of significant objective increase in function from prior interferential unit which was issued postoperatively therefore this request is not medically necessary.