

Case Number:	CM15-0039533		
Date Assigned:	03/09/2015	Date of Injury:	07/17/2006
Decision Date:	04/10/2015	UR Denial Date:	02/11/2015
Priority:	Standard	Application Received:	03/02/2015

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: Emergency 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 53-year-old female who sustained an industrial injury on 07/17/2006. Current diagnoses include right shoulder rotator cuff syndrome-status post surgery, left shoulder rotator cuff syndrome-status post rotator cuff repair and distal clavicle excision, cervical disc herniation-status post anterior cervical discectomy and fusion, overuse syndrome both upper extremities, and chronic thoracic strain. Previous treatments included medication management, bilateral shoulder surgery, cervical surgery with fusion, physical therapy, and home exercise program. Report dated 01/28/2015 noted that the injured worker presented with complaints that included cervical spine, thoracic, and bilateral shoulder and left hand pain. Pain level was rated as 5 out of 10 on the visual analog scale (VAS). Physical examination was positive for abnormal findings. The treatment plan included request for physical therapy to the cervical spine, thoracic spine, and bilateral shoulders, pending authorizations for flurbiprofen/lidocaine cream, and urine toxicology screen.

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 4 weeks (8) for the thoracic region: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines regarding physical therapy.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back, Acute and Chronic, Physical therapy.

Decision rationale: The requested Physical therapy 2 times a week for 4 weeks (8) for the thoracic region, is not medically necessary. American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), CHAPTER 8, Neck and Upper Back Complaints, Summary of Recommendations and Evidence, Page 181; and Official Disability Guidelines (ODG), Neck and Upper Back, Acute and Chronic, Physical therapy, recommend continued physical therapy with documented objective evidence of derived functional benefit. The injured worker has cervical spine, thoracic, and bilateral shoulder and left hand pain. The treating physician has not documented sufficient objective evidence of derived functional benefit from completed physical therapy sessions, nor the medical necessity for additional physical therapy to accomplish a transition to a dynamic home exercise program. The criteria noted above not having been met, Physical therapy 2 times a week for 4 weeks (8) for the thoracic region is not medically necessary.