

Case Number:	CM15-0061059		
Date Assigned:	04/07/2015	Date of Injury:	12/08/2007
Decision Date:	05/07/2015	UR Denial Date:	03/02/2015
Priority:	Standard	Application Received:	03/31/2015

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: Preventive Medicine, Occupational 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 58 year old female who sustained an industrial injury on 12/8/07. The injured worker reported symptoms in the right shoulder and back. The injured worker was diagnosed as having failed back syndrome, neural encroachment L3-4 and L4-5 with radiculopathy L5 and S1, spondylolisthesis L2-L3 and L3-L4, status post lumbar decompression L3-L4 (6/16/05), status post right arthroscopic subacromial decompression and bilateral wrist/hand pain. Treatments to date have included epidurals, oral pain medication, nonsteroidal anti-inflammatory drugs, transcutaneous electrical nerve stimulation unit, and Lumbar-Sacral Orthosis. Currently, the injured worker complains of right shoulder and back pain. The plan of care was for physical therapy, Electromyography, Nerve Conduction Velocity and a follow up appointment at a later date.

IMR ISSUES, DECISIONS AND RATIONALES

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

Continue with request for physical therapy for the right shoulder QTY: 12.00: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine section Page(s): 98, 99.

Decision rationale: The MTUS Guidelines recommend physical therapy focused on active therapy to restore flexibility, strength, endurance, function, range of motion and alleviate discomfort. The MTUS Guidelines support physical therapy that is providing a documented benefit. Physical therapy should be provided at a decreasing frequency (from up to 3 visits per week to 1 or less) as the guided therapy becomes replaced by a self-directed home exercise program. The physical medicine guidelines recommend myalgia and myositis, unspecified, receive 9-10 visits over 8 weeks. The requesting physician explains that physical therapy is needed to reverse deconditioning and gain strength to the right shoulder. The injured worker complains of feeling deconditioned and having painful limited range of motion of the right shoulder. Prior physical therapy and the status of a home exercise program is not discussed. The injured worker has been injured since 2007 and it would be expected that the injured worker has been educated regarding rehabilitation exercises already. A home exercise program should be continued beyond therapist directed physical medicine. Medical necessity of this request has not been established within the recommendations of the MTUS Guidelines. The request for continue with request for physical therapy for the right shoulder QTY: 12.00 is determined to NOT be medically necessary.

Continue with request for additional physical therapy for the lumbar spine QTY: 12.00:
Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine section Page(s): 98, 99.

Decision rationale: The MTUS Guidelines recommend physical therapy focused on active therapy to restore flexibility, strength, endurance, function, range of motion and alleviate discomfort. The MTUS Guidelines support physical therapy that is providing a documented benefit. Physical therapy should be provided at a decreasing frequency (from up to 3 visits per week to 1 or less) as the guided therapy becomes replaced by a self-directed home exercise program. The physical medicine guidelines recommend myalgia and myositis, unspecified, receive 9-10 visits over 8 weeks. The requesting physician explains that physical therapy is needed to reverse deconditioning and gain strength to the right shoulder. The injured worker complains of feeling deconditioned and having painful limited range of motion of the right shoulder. Prior physical therapy and the status of a home exercise program is not discussed. The injured worker has been injured since 2007 and it would be expected that the injured worker has been educated regarding rehabilitation exercises already. A home exercise program should be continued beyond therapist directed physical medicine. Medical necessity of this request has not been established within the recommendations of the MTUS Guidelines. The request for additional physical therapy for the lumbar spine QTY: 12.00 is determined to NOT be medically necessary.