

Case Number:	CM14-0117254		
Date Assigned:	09/16/2014	Date of Injury:	01/18/2013
Decision Date:	10/15/2014	UR Denial Date:	07/01/2014
Priority:	Standard	Application Received:	07/24/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 54-year-old female with a date of injury of 1/18/13. She complained of progressive pain at the neck, shoulders, knees, right foot, and bilateral hands. She rated her pain as 4/10 with medications and 6/10 without them. Sleep quality was poor. Exam showed decreased cervical, lumbar and right shoulder range of motion, cervical, bilateral hand, right knee and right foot tenderness. Positive orthopedic testing of the lumbar spine, right shoulder and right knee, proximal interphalangeal joint swelling bilaterally. Right knee exam indicated trace swelling with crepitus. Decreased light touch sensation over the thumb and index finger on the right, and decreased upper extremity reflexes in comparison with the lower extremity reflexes. Past history of heart disease, arrhythmia, bigeminy, and trigeminy were noted. Surgeries include status post bilateral knee surgeries. Current medications include Zanaflex 4 mg and Oxycodone HCL 10 mg. Past treatments include Norco which she failed to respond to, Vicodin, Ibuprofen, Tylenol, and Naproxen. She had cervical medial branch blocks but had headache afterwards. She had right shoulder subacromial steroid injection on 02/22/13, which helped tremendously. Diagnoses included shoulder internal derangement, B/L CTS, chronic cervical and L/S strain, right knee internal derangement and advanced degenerative changes of the medical compartment. There was no documentation regarding any previous physical therapy or diagnostic studies regarding low back. The request for Physical Therapy (PT) x 12 to low back was modified 10 PT sessions directed at the low back and 1 Right Shoulder Injection (Subacromial Injection of Local Anesthetic and a Corticosteroid Preparation Shoulder Injection): was denied on 07/01/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy x 12: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 98.

Decision rationale: As per CA MTUS guidelines, physical medicine is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. The guidelines recommend 9 visits over 8 weeks intervertebral disc disorders without myelopathy, 10 visits over 8 weeks for Lumbar sprains and strains, or Lumbago / Backache. CA MTUS - Physical Medicine; Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. In this case, there is no record of prior physical therapy progress notes with documentation of any significant improvement in the objective measurements (i.e. pain level, range of motion, strength or function) to demonstrate the effectiveness of physical therapy in this injured worker. Furthermore, there is no mention of the patient utilizing an HEP (At this juncture, this patient should be well-versed in an independently applied home exercise program, with which to address residual complaints, and maintain functional levels). There is no evidence of presentation of an acute or new injury with significant findings on examination to warrant any treatments. Furthermore, the request for physical therapy (PT) was previously modified to 10 visits according to guidelines. Therefore, the request for 12 PT visits is considered not medically necessary or appropriate in accordance with the guidelines.

1 Right Shoulder Injection (Subacromial Injection of Local Anesthetic and a Corticosteroid Preparation Shoulder Injection): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Shoulder (Acute and chronic)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder

Decision rationale: Per ODG, shoulder steroid injection criteria include: diagnosis of adhesive capsulitis, impingement syndrome or rotator cuff; pain not controlled adequately by recommended conservative treatment (PT, NSAIDs) after at least 3 months; pain interferes with functional activities; intended for short-term control of symptoms to resume conservative medical management. In this case, there is limited documentation as to previous conservative treatments per criteria. Thus, the request is considered not medically necessary.

