

Case Number:	CM14-0118278		
Date Assigned:	08/06/2014	Date of Injury:	11/30/2013
Decision Date:	10/21/2014	UR Denial Date:	07/22/2014
Priority:	Standard	Application Received:	07/28/2014

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, has a subspecialty in Pain Medicine 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:

This is a patient with a date of injury of November 30, 2013. A utilization review determination dated July 22, 2014 recommends noncertification of additional physical therapy. Noncertification was recommended since the patient has already completed 12 therapy sessions with no documentation of objective functional improvement. A progress report dated June 11, 2014 identifies subjective complaints of thoracic spine pain, lumbar spine pain, right shoulder pain, right wrist and hand pain, and fibromyalgia. Physical examination findings reveal painful thoracic range of motion, spasm and tenderness in the thoracic paraspinal muscles, painful lumbar range of motion, spasm and tenderness in the lumbar paraspinal muscles, restricted shoulder range of motion, spasm and tenderness in the right shoulder, painful wrist and hand range of motion, spasm and tenderness in the right wrist. Diagnoses include lumbar disc displacement, sciatica, thoracic disc displacement, partial tear of the rotator cuff, carpal sprain/strain, obesity, diabetes, and fibromyalgia. The treatment plan recommends physical medicine for 6 visits with treatment goals of increasing activities of daily living and decreasing work restriction and need for medication. The note indicates that the patient was trained in a series of home exercise. Additionally, an MRI is requested for the patient's lumbar spine and right shoulder, and medications have been prescribed. A functional capacity evaluation, multi-interferential stimulator, and lumbosacral orthosis are also recommended. A physical therapy note dated February 20, 2014 indicates that 13 therapy visits have been provided for thoracic, lumbar, and right shoulder issues.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Medicine 3 times a week for 2 weeks Thoracic & Lumbar, Right Shoulder, Hand & Wrist: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines Page(s): Pages 58, 99. Decision based on Non-MTUS Citation Official Disability Guidelines-Physical Therapy Low Back, Shoulder, Forearm and Wrist & Hand

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 12 Low Back Complaints Page(s): 298 200, Chronic Pain Treatment Guidelines Page(s): 98 of 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Physical Therapy, Shoulder Chapter, Physical Therapy

Decision rationale: Regarding the request for physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. ODG recommends a maximum of 10 therapy visits for inter vertebral disc disorders of the lumbar spine. ODG recommends a maximum of 10 visits of physical therapy for the treatment of rotator cuff disorders. Within the documentation available for review, there is no indication of any specific objective treatment goals which could not be addressed with an independent program of home exercise. Furthermore, the request exceeds the amount of PT recommended by the ODG and, unfortunately, there is no provision for modification of the current request. In the absence of such documentation, the current request for physical therapy is not medically necessary.