MAXIMUS Federal Services

Case Number:	CM14-0118847		
Date Assigned:	09/16/2014	Date of Injury:	12/17/2012
Decision Date:	10/22/2014	UR Denial Date:	07/21/2014
Priority:	Standard	Application Received:	07/29/2014

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 Occupational 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:

The injured worker is a 37-year-old male who was injured on December 17, 2012. Diagnoses were listed as sprain lumbar region (847.2). The most recent progress note, dated 7/8/14, revealed complaints of lower back pain, left lower extremity pain, and right lower extremity pain. The injured worker rated his pain as 8 out of 10 on the visual analog scale (VAS); it was described as both aching and sharp. There were no complaints of shoulder pain. The injured worker felt fatigued and complained of reduced energy. Physical examination revealed bilateral [shoulder] flexion and abduction of 160 degrees each limited by end range pain. It was documented that the pain radiated to the left thigh, right thigh, left leg, right leg, left foot and right foot. The injured worker reported that the medications were working and well tolerated. The injured worker reported that his quality of sleep was poor. Pain is managed well with the current medication regimen. Prior treatment included twenty-two chiropractic adjustments and [unspecified] physiotherapy. Medications included cyclobenzaprine 7.5 milligrams, hydrocodone 2.5/325 milligrams, and Menthoderm gel. A prior utilization review determination dated 7/21/14 resulted in denial of payment for eight physical therapy visits for the left shoulder with evaluation as outpatient between 7/15/14 and 8/28/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

8 Physical Therapy visits for the left shoulder with evaluation as outpatient between 7/15/14 and 8/28/14: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Standard of practice

Decision rationale: There were no complaints of shouler pain or dysfunction. His range of motion of the shoulders was very close to normal. In addition, the readiation reported is competely non-physioogic. There is therefore no rationale for this request deeming it not medically necessary.