

Case Number:	CM14-0161513		
Date Assigned:	10/06/2014	Date of Injury:	10/19/2011
Decision Date:	11/03/2014	UR Denial Date:	09/25/2014
Priority:	Standard	Application Received:	10/01/2014

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 male with a date of injury on 10/19/2011. As per the report of 9/11/14, he complained of back pain radiating from low back down the right leg, as well as right shoulder and right hip pain. He rated his pain with medications as 8/10 and 10/10 without. He was taking medications with good relief and with no side effects or abuse. He was not trying any other therapies for pain relief. He had memory impairments. On exam, he was assisted by cane. An exam of C-spine revealed tenderness of the paracervical muscles and trapezius. Exam of L-spine revealed range of motion (ROM) of flexion, extension, and left lateral bending limited by pain. Paravertebral muscles revealed spasm and tenderness to palpation on the right side. Lumbar facet loading was positive on the right side. Right shoulder exam revealed open surgical scar, limited range of motion (ROM), and positive Hawkins, Neer, and drop-arm tests. On palpation, tenderness was noted in the subdeltoid bursa. Hip range of motion (ROM) was limited by pain. Motor strength of extensor hallucis longus (EHL) was 4/5 on right and ankle dorsi flexor was 4/5 on right. Sensory exam revealed decreased sensation over L4 and S1 distributions on the right side. Straight leg raising (SLR) was positive on the right side. A magnetic resonance imaging (MRI) of L-spine dated 05/27/14 revealed L5-S1 disc protrusions with facet arthropathy and marked left foraminal stenosis, L4-5 disc protrusion with marked bilateral foraminal stenosis, and L2-3 disc protrusion. Magnetic resonance (MR) arthrogram of the right shoulder was done (undated). He underwent right full thickness rotator cuff repair and superior labrum anterior posterior (SLAP). Current medications include Dexilant DR, Ambien, Naprosyn, tizanidine HCl, and Ultram. He was using Ultram sparingly as it caused constipation, but decreased his pain. Naproxen was very effective and decreased his pain by more than 50%. Past treatments have included physical therapy (PT) with no benefit and epidural steroid injection (ESI) with greater than 50% improvement. Diagnoses include rotator cuff disease, radiculopathy,

hip bursitis and lumbar facet syndrome. The request for 12 physical therapy sessions for lumbar spine was denied on 09/25/14 in accordance with medical guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Twelve (12) physical therapy sessions for lumbar spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Physical Therapy (PT)

Decision rationale: As per the California Medical Treatment Utilization Schedule (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 Official Disability Guidelines (ODG) recommends 9 visits over 8 weeks intervertebral disc disorders without myelopathy. In this case, the injured worker has already received unknown number of physical therapy visits. However, there is little to no documentation of any significant improvement in the objective measurements (i.e. pain level, range of motion, strength or function) with physical therapy to demonstrate the effectiveness of this modality in this injured worker. There is no evidence of presentation of any new injury / surgical intervention. Moreover, additional physical therapy (PT) visits would exceed the guidelines criteria. Furthermore, there is no mention of the patient utilizing a home exercise program (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. Therefore, the request is considered not medically necessary or appropriate in accordance with the guideline.