

Case Number:	CM14-0168467		
Date Assigned:	10/16/2014	Date of Injury:	12/19/2013
Decision Date:	11/18/2014	UR Denial Date:	10/01/2014
Priority:	Standard	Application Received:	10/13/2014

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 & Rehabilitation, and is licensed to practice in Connecticut. 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 66 year old male who reported an injury on 12/19/2013. The mechanism of injury was not specified. His diagnoses include shoulder arthralgia, elbow arthralgia, lumbar/lumbosacral disc degeneration, cervicalgia, low back syndrome, shoulder sprain/strain rotator cuff, cervical myofascial sprain-strain, elbow contusion. Diagnostic studies included an MRI of the upper extremity right on 04/01/2014. On 07/29/2014 the injured worker reported popping with shoulder motion. The physical assessment the injured worker had right shoulder abduction to 110 degrees with pain. Lumbar spine range of motion was assessed and it was noted flexion was 85 degrees and extension was 25 degrees. On 09/09/2014 the injured worker complained of right shoulder pain radiating to the arm and hand, with decreased grip. The injured worker reported low back pain rated 8/10 and neck pain rated 7/10. There was stiffness to the cervical spine. The injured worker had right shoulder abduction to 120 degrees. Lumbar spine range of motion was assessed and it was noted flexion was 80 degrees and extension was 20 degrees. The injured worker's medication regimen included diclofenac sodium 75mg delayed release 1 tablet twice daily, soma 350mg tablet at bedtime, voltaren gel 1% apply 2gm to affected area. A request was received for Physical therapy two times a week for six weeks for the cervical spine, lumbar spine and right shoulder. The Request for Authorization form was dated 05/02/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy two times a week for six weeks for the cervical spine, lumbar spine and right shoulder: 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): 98-99.

Decision rationale: The request for Physical therapy two times a week for six weeks for the cervical spine, lumbar spine and right shoulder is not medically necessary. The injured worker was noted to have decreased range of motion of the lumbar spine and right shoulder. The California MTUS Guidelines recommend allowing for a fading of treatment frequency from up to 3 visits per week to 1 or less, plus participation in an active self-directed home Physical Medicine program. Furthermore the utilization of therapeutic exercise and activity are useful in restoring flexibility, strength, endurance, function, range of motion and can lessen discomfort. The guidelines recommend 9-10 sessions of physical therapy over 8 weeks. There is a lack of documentation demonstrating whether the injured worker has had physical therapy previously, as well as the efficacy of any prior sessions of physical therapy. The request for 12 sessions of physical therapy would exceed the guideline recommendations. Additionally, the requesting physician did not provide an adequate assessment of the cervical spine with documentation of quantified objective range of motion and strength values. As such, the request for physical therapy two times a week for six weeks for the cervical spine, lumbar spine and right shoulder not medically necessary.