

Case Number:	CM14-0172054		
Date Assigned:	10/23/2014	Date of Injury:	09/18/2007
Decision Date:	12/24/2014	UR Denial Date:	09/23/2014
Priority:	Standard	Application Received:	10/17/2014

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 Emergency 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 50 year old female who was injured on September 18, 2007. Mechanism of injury was documented as a backwards fall. Results of the injury include the cervical and lumbar spine region. Progress report dated May 19, 2014 showed severe neck and low back pain with limited range of motion. Diagnoses include lumbar herniated nucleus pulposus, cervical herniated nucleus pulposus, bilateral shoulder impingement, acute and chronic right shoulder rotator cuff tendonitis, bursitis, and impingement superimposed on previous work related injuries with the same employer. Patient is status post 4 surgeries with residuals from massive rotator cuff tear, left shoulder rotator cuff tendinitis, bursitis and impingement compensable secondary to overcompensation to the right shoulder, lumbosacral strain with intermittent but non verifiable left greater than right leg radiculopathy, cervical strain without complaints or findings of radiculopathy. Treatment modalities included Naprosyn, physical therapy, and epidural steroid injection. Utilization review dated 4/10/14 documents approval of 8 sessions of physical therapy. Magnetic resonance imaging dated December 8, 2013 showed a C5-C6 and C6-C7 herniated disc, mild and a moderate L1-L2 herniated disc. EMG /NCV test dated March 16, 2012 demonstrated no evidence of radiculopathy. Work status as of May 19, 2014 showed total temporary disability. Utilization review form dated September 23, 2014 non certified physical therapy 2 x 6 for lumbar and cervical due to lack of supporting documentation. Patient has documented PT sessions but no recent progress note to document progress or rationale behind request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 2 times a week for 6 weeks for the lumbar and cervical: 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: As per MTUS Chronic pain guidelines physical therapy is recommended for many situations with evidence showing improvement in function and pain. Guideline recommend documentation of objective functional improvement before any additional physical therapy is recommended. Patient has completed at least 8 prior PT sessions and there is no documentation submitted that provides rationale or documentation of improvement with physical therapy. Request for additional physical therapy is not medically necessary.