

Case Number:	CM14-0088827		
Date Assigned:	07/23/2014	Date of Injury:	03/28/1957
Decision Date:	11/12/2014	UR Denial Date:	05/21/2014
Priority:	Standard	Application Received:	06/12/2014

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 57-year-old male who reported injury on 03/06/2013. The mechanism of injury was not provided. The injured worker's diagnoses included cervical disc herniation without myelopathy, thoracic disc displacement without myelopathy, partial tear of rotator cuff tendon of the left shoulder, and bursitis/tendonitis of the bilateral shoulders. The injured worker's past treatments include medications and physical therapy. The injured worker's diagnostic testing was not provided. The injured worker's surgical history was not provided. On the clinical note dated 04/30/2014, the injured worker complained of pain to the cervical spine, right shoulder, thoracic spine, and left shoulder. The injured worker had +3 spasm and tenderness to the bilateral paraspinal muscles from C4-7 and bilateral suboccipital muscles, range of motion was noted to be measured by an external goniometer or digital protractor. The injured worker was noted to be positive bilaterally for neurological compromise on axial compression test. The injured worker's shoulder depression test was positive bilaterally, Kemp's was positive bilaterally, speeds test was positive bilaterally, and supraspinatus test was positive bilaterally. The injured worker's medications included transdermal compounds; inflammation topical compound of lidocaine 6%, gabapentin 10%, tramadol 10%, applied twice a day, and flurbiprofen 15%/cyclobenzaprine 2%/baclofen 2%/lidocaine 5% applied twice daily. The request was for followup visits with range of motion measurements and addressing ADLs, electrical stimulation x6 to bilateral shoulders, infrared to cervical and thoracic spine, chiropractic manipulative therapy to the cervical and thoracic spine, massage to bilateral shoulders and thoracic spine, and therapeutic activities to bilateral shoulders, wall climbs/theraband. The rationale was due to the injured worker's subjective complaints and objective findings. The Request for Authorization form was submitted for review on 03/24/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Follow up visits with range of motion measurements and addressing ADL`s: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: The request for follow up visits with range of motion measurements and addressing ADL`s is not medically necessary. The injured worker is diagnosed with cervical disc herniation without myelopathy, thoracic disc displacement without myelopathy, partial tear of rotator cuff tendon of the left shoulder, and bursitis/tendonitis of the bilateral shoulders. The California MTUS Guidelines state active therapy 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. Guidelines recommend 9 to 10 visits over 8 weeks. The requesting physician did not provide a recent clinical note with an assessment of the injured worker's condition. The medical records lack documentation of significant objective functional deficits to warrant additional visits to physical therapy. There is a lack of documentation indicating the injured worker's previous number of visits and efficacy of the prior therapy. There is lack of documentation indicating improved pain rating from physical therapy. Additionally, the request does not indicate the number of visits as well as the body part which the request of physical therapy is for. As such, the request for follow up visits with range of motion measurements and addressing ADL`s is not medically necessary.

Electrical Stim x 6 to bilateral shoulders.: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Massage therapy Page(s): 60.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: The request for electrical stim x 6 to bilateral shoulders is not medically necessary. This request is a modality of the initial request of physical therapy (G0283). Given the initial request was not medically necessary, modalities for initial request would also not be medically necessary. As such, the request for electrical stim x 6 to bilateral shoulders is not medically necessary.

Infrared to Cervical and Thoracic spine.: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Massage therapy Page(s): 60.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: The request for infrared to cervical and thoracic spine is not medically necessary. This request is a modality of the initial request of physical therapy (97026). Given the initial request was not medically necessary, modalities for initial request would also not be medically necessary. As such, the request for infrared to cervical and thoracic spine is not medically necessary.

Chiropractic Manipulative therapy to the Cervical and Thoracic Spine.: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: The request for chiropractic manipulative therapy to the cervical and thoracic spine is not medically necessary. This request is a modality of the initial request of physical therapy (98941). Given the initial request was not medically necessary, modalities for initial request would also not be medically necessary. As such, the request for chiropractic manipulative therapy to the cervical and thoracic spine is not medically necessary.

Massage to Bilateral shoulders and thoracic spine.: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Massage therapy Page(s): 60.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: The request for massage to bilateral shoulders and thoracic spine is not medically necessary. This request is a modality of the initial request of physical therapy (97124). Given the initial request was not medically necessary, modalities for initial request would also not be medically necessary. As such, the request for massage to bilateral shoulders and thoracic spine is not medically necessary.

Therapeutic activities to Bilateral shoulders, wall climbs / theraband.: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: The request for therapeutic activities to bilateral shoulders, wall climbs / theraband is not medically necessary. This request is a modality of the initial request of physical therapy (97530). Given the initial request was not medically necessary, modalities for initial request would also not be medically necessary. As such, the request for therapeutic activities to bilateral shoulders, wall climbs / theraband is not medically necessary.