

Case Number:	CM14-0217701		
Date Assigned:	01/07/2015	Date of Injury:	05/17/2014
Decision Date:	03/30/2015	UR Denial Date:	12/17/2014
Priority:	Standard	Application Received:	12/29/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: New York, Tennessee
 Certification(s)/Specialty: Emergency Medicine

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 52 year old female with an industrial injury dated 05/17/2014 as a result of a fall. Her diagnoses include traumatic brain injury with post-concussion symptoms, cervical spine strain/sprain with left radiculitis, lumbar spine strain/sprain with right radiculitis, bilateral shoulder strain/sprain rule out rotator cuff tear, and right triceps strain rule out tear. Recent diagnostic testing has included x-rays of the cervical and lumbar spines and bilateral shoulders (11/21/2014) revealing significant abnormalities throughout. She has been treated with pain medications and muscle relaxants for several months. Other treatments have included previous physical therapy, chiropractic treatments, and cortisone injections to the left shoulder (09/2014). In a progress note dated 11/20/2014, the treating physician reports constant mild to severe pain in the cervical spine with soreness, stiffness, radiating pain the upper back and left upper extremity, radiating burning pain to the right upper extremity, frontal and occipital tension with occasional dizziness and blurred vision, mild to moderate pain in the lumbar spine with stiffness and soreness and radiating pain, numbness and tingling into the hips and buttocks, constant moderate to severe pain in the left shoulder with stiffness and soreness that radiates to the elbow, forearm and wrist with weakness and numbness in the left hand, and intermittent severe pain in the right shoulder with stiffness and soreness that radiates to the right upper arm and right side of neck, and right triceps pain with loss of power and bruising. The objective examination revealed decreased range of motion in the cervical spine, tenderness to palpation of the cervical spine, decreased sensation in the left 2nd digit, diffuse tenderness to palpation of the bilateral shoulders, decreased range of motion in the left shoulder, a positive impingement test on the right side, and

tenderness to palpation of the lumbar spine with decreased range of motion. The treating physician is requesting physical therapy for the cervical and lumbar spines, and the bilateral shoulders which was denied by the utilization review. On 12/17/2014, Utilization Review non-certified a request for physical therapy 3 times per week for 4 weeks for the treatment of the cervical spine, lumbar spine and bilateral shoulders, noting the lack of decreased pain by a lower visual acuity score, lack of noted functional improvement, and the absence of a documented decrease in the injured worker's medications as a result from previous physical therapy. The MTUS and ODG Guidelines were cited. On 12/29/2014, the injured worker submitted an application for IMR for review of physical therapy 3 times per week for 4 weeks for the treatment of the cervical and lumbar spine, and the bilateral shoulders.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy for cervical spine, lumbar spine & bilateral shoulders 3x/wk x 4 wks:
Upheld

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

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

Decision rationale: Chronic Pain Medical Treatment Guidelines state that there is no high-grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities such as traction, heat/cold applications, massage, diathermy, TENS units, ultrasound, laser treatment, or biofeedback. They can provide short-term relief during the early phases of treatment. Active treatment is associated with better outcomes and can be managed as a home exercise program with supervision. ODG states that physical therapy is more effective in short-term follow up. Patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy). When treatment duration and/or number of visits exceed the guideline, exceptional factors should be noted. Recommended number of visits for myalgia and myositis is 9-10 visits over 8 weeks; and for neuralgia, neuritis, and radiculitis is 8-10 visits over 4 weeks. In this case the requested number of 12 visits surpasses the number of six recommended for clinical trial to determine functional improvement. The request should not be authorized.