

Case Number:	CM15-0009448		
Date Assigned:	01/27/2015	Date of Injury:	11/18/2010
Decision Date:	03/17/2015	UR Denial Date:	12/26/2014
Priority:	Standard	Application Received:	01/16/2015

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: California, Indiana, New York
Certification(s)/Specialty: Internal 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:

This is a 50 year old male with an industrial injury dated 11/18/2010. The injured worker presents on 11/10/2014 for follow up. He complains of moderate pain in the cervical spine and bilateral shoulders with pain radiating down into both hands. He also complains of severe pain in the lumbar spine radiating down the legs. There was bilateral cervical paraspinal tenderness noted on exam. There was limited range of motion of bilateral shoulders. Lumbar spine exam revealed tenderness in the lumbar paraspinal bilaterally. Diagnoses included displacement of cervical intervertebral disc without myelopathy, cervical radiculitis, lumbar radiculitis, right shoulder rotator cuff syndrome, right shoulder tendinitis and right shoulder adhesive capsulitis. MRI of the left wrist dated 02/11/2014 showed a small tear of the TFCC (triangular fibrocartilage complex) as noted by provider. Prior treatments include physical therapy, psychiatry follow up and home exercise program. On the request for physical therapy 3 times a week over 8 weeks of the cervical spine, lumbar spine and right shoulder was non-certified by utilization review. MTUS and ODG were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 3 x a week x 8 weeks, cervical spine, lumbar spine and right shoulder:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck & Upper Back (updated 11/18/2014, Physical Therapy (PT); Low Back (updated 11/21/2014) Physical Therapy (PT); Shoulder (updated 10/31/2014), Physical Therapy

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98-99. Decision based on Non-MTUS Citation Neck, low back, shoulder sections, Physical therapy

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, physical therapy three times per week for eight weeks to the cervical spine, lumbar spine and right shoulder is not medically necessary. 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 negative direction (prior to continuing with physical therapy). When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted. In this case, the injured worker's working diagnoses are displacement of cervical intervertebral disc without myelopathy; displacement of lumbar intervertebral disc without myelopathy; cervical radiculitis; lumbar radiculitis; right shoulder rotator cuff syndrome; right shoulder tendinitis; right shoulder adhesive capsulitis; and GERD. Subjectively, the injured worker complains of moderate pain in the cervical spine and bilateral shoulders radiating down both hands. There was also severe pain in the lumbar spine with radiating pain down the legs. Objectively, there is tenderness in the bilateral cervical paraspinal muscle groups. Range of motion is decreased. Shoulder examination has a positive impingement sign on the right. Lumbar spine is tender to palpation paraspinal muscle groups. Range of motion is decreased. The documentation indicates the injured worker had 59 physical therapy visits to date with minimal relief. There are no physical therapy notes in the medical record. There is no documentation of objective functional improvement associated with prior physical therapy. When treatment duration and/or number of visits exceeded the guidelines, exceptional factors should be noted. There are no compelling clinical facts/exceptional factors in the medical record to warrant additional physical therapy. Consequently, absent compelling clinical documentation with evidence of objective functional improvement having had 59 physical therapy sessions to date with minimal relief, physical therapy three times per week for eight weeks (24 sessions) is not medically necessary.