

Case Number:	CM15-0116325		
Date Assigned:	06/24/2015	Date of Injury:	02/17/2014
Decision Date:	07/23/2015	UR Denial Date:	05/29/2015
Priority:	Standard	Application Received:	06/16/2015

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

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 46 year old male with a February 17, 2014 date of injury. A progress note dated November 7, 2014 documents subjective complaints (neck pain; lower back pain; right shoulder pain; bilateral elbow pain; bilateral wrist and hand pain; bilateral hip pain; bilateral knee pain; bilateral ankle and foot pain; abdominal pain; inguinal pain; blurred vision), objective findings (tenderness predominantly over the right paracervical musculature; diffuse tenderness of the thoracic spine; tenderness to palpation noted over the paralumbar musculature; straight leg raise positive on the right; tenderness to palpation noted over the posterior aspect of the shoulder joint; positive impingement test on the right; tenderness to palpation noted over the lateral humeral epicondyle; tenderness to palpation noted over the radiocarpal joint; tenderness to palpation noted over the metacarpophalangeal and proximal interphalangeal joints in both hands; unable to make a full fist with the right hand; tenderness to palpation noted over the posterolateral aspect of the hip joint; tenderness over the lateral knee joints) and current diagnoses (sprain/strain, cervical spine; sprain/strain, thoracic spine; sprain/strain, lumbar spine; sprain/strain, left shoulder; impingement syndrome, right shoulder; bilateral lateral epicondylitis; sprain/strain, wrist, bilateral; sprain/strain, hand, bilateral; sprain/strain, hip, bilateral; sprain/strain, right knee; sprain/strain, ankle, bilateral; anxiety and depression). Treatments to date have included chiropractic treatment, therapeutic activities, extracorporeal shockwave therapy, and magnetic resonance imaging of the lumbar spine (July 11, 2014; showed disc desiccation at L5-S1; L5-S1 broad-based posterior disc herniation which causes stenosis of the spinal canal and the bilateral neural foramen). The treating physician requested retrospective authorization for therapeutic

activities continued to the neck, upper back, low back, right shoulder and right knee for the dates of service of September 16, 2014 through September 30, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective 4 therapeutic activities continued to the neck, upper back, low back, right shoulder and right knee (dos:09/16/14-09/30/14): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical therapy (PT), Physical medicine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Therapy, pages 98-99.

Decision rationale: The patient has received significant conservative care to include 14 PT visits with 8 therapeutic activities and 10 chiropractic sessions. Therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. However, there is no clear measurable evidence of progress with the therapy treatment already rendered including milestones of increased ROM, strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints, clinical findings, and functional status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. The Chronic Pain Guidelines allow for visits of therapy with fading of treatment to an independent self-directed home program. It appears the employee has received significant therapy sessions without demonstrated evidence of functional improvement to allow for additional therapy treatments. There is no report of acute flare-up, new injuries, or change in symptom or clinical findings to support for formal therapy in a patient that has been instructed on a home exercise program for this chronic injury. Submitted reports have not adequately demonstrated the indication to support further therapeutic activities when prior treatment rendered has not resulted in any functional benefit. The Retrospective 4 therapeutic activities continued to the neck, upper back, low back, right shoulder and right knee (dos:09/16/14-09/30/14) is not medically necessary and appropriate.