MAXIMUS Federal Services

Case Number:	CM15-0122447		
Date Assigned:	07/06/2015	Date of Injury:	07/30/2013
Decision Date:	07/31/2015	UR Denial Date:	06/08/2015
Priority:	Standard	Application Received:	06/25/2015

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:

The injured worker is a 57-year-old male who sustained an industrial injury on 7/30/13. Diagnoses are cervical spine pain, lumbar pain, shoulder impingement, and right knee meniscus tear. In a progress report dated 3/18/15, a treating physician notes the MRI of the lumbar spine dated 5/25/14, demonstrates grade 1 anterolisthesis L4 on L5 due to facet arthrosis and disc desiccation at L4-L5. At L3-L4, there is concentric posterior annular disc bulge. At L4-L5 there is diffuse concentric posterior annular disc bulge. In extension and neutral position this is 4 millimeters. The MRI of the right shoulder dated 5/24/15, demonstrates supraspinous and infraspinatus tendinosis, superior labral tear from posterior to anterior type 1 or 2 tear, posterior labral tear, and pronounced anterior-inferior downsloping of the acromiun. In a progress report dated 5/27/15, a treating physician notes complaints of back, shoulder and right knee pain. The injured worker reports he is having control over the symptoms with the Tramadol he takes. He has declined surgical intervention in the past and continues to do so. Examination of the lumbar spine notes tenderness over the paraspinal musculature. Straight leg raise is negative. Examination of the right shoulder notes positive Neer, Hawkins and Jobes signs. The treatment plan is therapy for the right shoulder and lumbar spine and refill Tramadol, which keeps him pain relieved. He remains on work restrictions. Previous treatment includes physical therapy, a lumbar support, Tramadol, and Tylenol. The requested treatment is physical therapy two times a week for four weeks for the lumbar spine and right shoulder for a quantity of 8.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy two times a week for four weeks for the lumbar spine and right shoulder qty: 8. 00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, Pain, Suffering, and the Restoration of Function Chapter, page 114 Official Disability Guidelines (ODG), Shoulder and Low Back Chapters.

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

Decision rationale: Physical therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical 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 PT 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 physical 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 PT 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 physical therapy when prior treatment rendered has not resulted in any functional benefit. The Physical therapy two times a week for four weeks for the lumbar spine and right shoulder qty: 8. 00 is not medically necessary and appropriate.