

Case Number:	CM15-0125383		
Date Assigned:	07/09/2015	Date of Injury:	09/11/2013
Decision Date:	08/05/2015	UR Denial Date:	06/23/2015
Priority:	Standard	Application Received:	06/29/2015

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 29-year-old male with an industrial injury dated 09/11/2013. The injured worker's diagnoses include post-concussion headache status post fall, low back pain, T12 thoracic fracture and L1 lumbar fracture, status post right forearm fracture and surgery, left wrist fracture, pain in the wrists and hands, left shoulder pain, insomnia and irritability. Treatment consisted of diagnostic studies, prescribed medications, waist brace, and periodic follow up visits. In a panel qualified medical evaluation report dated 06/03/2015, the injured worker reported headache, hand pain, left shoulder pain, low back pain, occasional pain in the soles and insomnia. Objective findings revealed tenderness over the lumbosacral spinous processes and slight antalgic gait. The treating physician prescribed services for physical therapy 2 x 4 for the left shoulder now under review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 2 x 4 for the left shoulder: Upheld

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

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

Decision rationale: Review indicates the patient has received previous PT sessions with current request modified to authorize for 6 additional visits. Submitted reports have no acute flare-up or specific physical limitations to support for physical/ occupational therapy. 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. Submitted reports have no acute flare-up or specific physical limitations to support for physical/ occupational therapy. The Chronic Pain Guidelines allow for 9-10 visits of therapy with fading of treatment to an independent self-directed home program. It appears the patient has received prior sessions of PT/OT without clear specific functional improvement in ADLs, functional status, or decrease in medication and utilization without change in neurological compromise or red-flag findings to support further treatment. The Physical therapy 2 x 4 for the left shoulder is not medically necessary and appropriate.