MAXIMUS Federal Services

Case Number:	CM15-0127878		
Date Assigned:	07/14/2015	Date of Injury:	05/08/2013
Decision Date:	08/10/2015	UR Denial Date:	06/17/2015
Priority:	Standard	Application Received:	07/01/2015

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: Preventive Medicine, Occupational 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 48 year old female who sustained an industrial injury on 05/08/2013. The accident was described as while working as a production worker in a factory as she was returning from the restroom back to the conveyor belt she lost her balance on a wet surface and fell onto the left side of her body with resulting pain and injury. Se reported the injury was evaluated and treated with diagnostic radiography testing, activity modification, prescribed both medications and physical therapy course. The pain persisted and she was referred to pain management around August 2013. She continues following pain management for regimen of pharmaceuticals. Thereafter she obtained surgical consultation and was referred to undergo a magnetic resonance imaging study of left shoulder and suggested surgery without any further action. She has had a prior claim involving the low back in 1990 that was treated with a course of physical therapy. She is taking Naproxen 500mg. A MRI done on 08/07/2013 showed cervical C5-6 disc osteophyte central left paracentral disc protrusion and minor additional degenerative changes. The QME evaluator documented prior courses of physical therapy for the spine and 14 sessions completed for the shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy 1 x 6 weeks, for the Cervical Spine, Lumbar Spine, Thoracic and Left Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines Page(s): 99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98, 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder/ Physical Therapy.

Decision rationale: MTUS Guidelines consider up to 10 sessions of guided physical therapy as adequate for most chronic conditions with the goal of a independent self motivated exercise program. It is clearly documented that this individual has had a least 1 prior course of physical therapy for her spinal condition. A couple of sessions may be reasonable to renew/upgrade her current program for her spine, but an additional 6 sessions significantly exceeds Guideline recommendations. ODG Guidelines recommend up to 10 sessions of physical therapy as adequate for SLAP tears and up to 16 sessions of therapy for adhesive capsulitis. It is documented that this individual has completed 14 sessions of therapy for the shoulder. A couple of additional sessions for the shoulder adhesive capsulitis would be consistent with Guidelines, but the request for 6 additional sessions significantly exceeds Guidelines and there are no unusual circumstances to justify an exception to Guidelines. The request for Physical Therapy 1 x 6 weeks, for the Cervical Spine, Lumbar Spine, Thoracic and Left Shoulder is not supported by Guidelines and is not medically necessary.