

Case Number:	CM15-0070232		
Date Assigned:	04/20/2015	Date of Injury:	06/18/2003
Decision Date:	05/18/2015	UR Denial Date:	03/27/2015
Priority:	Standard	Application Received:	04/14/2015

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, Pain Management

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 69 year old female, who sustained an industrial injury on June 18, 2003. The injured worker was diagnosed as having right shoulder rotator cuff repair, regional pain syndrome, lumbar degenerative disc disease (DDD), laminectomy, fusion and spinal cord stimulator implant and removal. Treatment and diagnostic studies to date have included rotator cuff repair with revision, spinal cord stimulator, acupuncture, physical therapy and medication. A progress note dated March 17, 2015 provides the injured worker complains of low back pain radiating to legs with numbness and tingling. She also reports right shoulder pain. She rates her pain 7/10 with medication and 10/10 without medication. Physical exam notes mild to moderate discomfort and slight depression. There is cervical tenderness with decreased range of motion (ROM), right shoulder impingement with painful decreased range of motion (ROM) and lumbar tenderness with spasm. The plan includes oral and topical medication, physical therapy and psychiatric consultation. A progress report dated March 31, 2015 states that the patient completed 12 physical therapy sessions in December 2014. The patient reports that the physical therapy is beneficial for reducing muscle spasms, improving range of motion, strength, and endurance. Objective examination reveals improvement in range of motion and decreased spasms. 8 sessions of therapy are currently being requested for a flareup of symptoms.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy, 2 times weekly for 4 weeks, Low Back: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298, Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 98 of 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Physical Therapy.

Decision rationale: Regarding the request for additional physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, it appears the patient has already undergone 12 sessions for the diagnosis of lumbar radiculopathy. Guidelines recommend a maximum 12 visits for this diagnosis. The requesting physician has indicated that the patient had a flare-up. If, the additional therapy is being requested for a new diagnosis, then a 6-visit clinical trial may be indicated. However, the currently requested 8 visits exceeds the maximum number recommended as a trial by guidelines. Furthermore, if these therapy sessions are being requested for the previous diagnosis, then the overall number of therapy sessions, including those currently requested as well as those previously provided, exceeds the maximum number recommended by guidelines for the patient's diagnosis with no documentation of any complicating factors. Furthermore, there is no indication as to why an independent program of home exercise would be insufficient to address any current issues. In light of the above issues, the currently requested additional physical therapy is not medically necessary.