

Case Number:	CM15-0070290		
Date Assigned:	04/17/2015	Date of Injury:	09/21/2013
Decision Date:	05/19/2015	UR Denial Date:	03/19/2015
Priority:	Standard	Application Received:	04/13/2015

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 65 year old male, who sustained an industrial injury on 09/21/2013. He has reported injury to the neck, left shoulder, left elbow, and low back. The diagnoses have included cervical spine pain; cervical radiculopathy; left shoulder pain/strain; left elbow lateral epicondylitis; and lumbar spine radiculopathy. Treatment to date has included medications, diagnostics, shockwave therapy, and physical therapy. Medications have included Synapryn, Tabradol, Fanatrex, and Terocin patches. A progress note from the treating physician, 02/05/2015, documented a follow-up visit with the injured worker. Currently, the injured worker complains of constant radicular neck pain, greater on the left side, which is rated at 6/10 on the visual analog scale; neck pain is associated with numbness and tingling of the bilateral upper extremities; and constant pain to the left shoulder, left elbow, left wrist, and low back. Objective findings included tenderness to palpation of the cervical spine, left shoulder, left elbow, left wrist, and lumbar spine. The treatment plan has included the request for physical therapy three times a week for six weeks cervical spine, left shoulder, left elbow. A progress report dated September 4, 2014 recommends continuing physical therapy. Physical therapy notes dated December 15, 2014 indicate that the patient has undergone 12 out of 12 therapy sessions.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 3xwk x 6 wks cervical spine, Left shoulder, Left elbow: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints Page(s): 173, 200, Chronic Pain Treatment Guidelines Page(s): 98 of 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck & Upper Back Chapter, Physical Therapy, Elbow Chapter, Physical Therapy, Shoulder 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, there is documentation of completion of prior PT sessions, but there is no documentation of specific objective functional improvement with the previous sessions and remaining deficits that cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised therapy. Additionally, it is unclear how many therapy sessions have already been provided for the ankle/foot, making it impossible to determine if the patient has exceeded the maximum number recommended by guidelines for his diagnosis. In light of the above issues, the currently requested additional physical therapy is not medically necessary.