

Case Number:	CM15-0071956		
Date Assigned:	04/22/2015	Date of Injury:	06/21/2014
Decision Date:	05/20/2015	UR Denial Date:	04/08/2015
Priority:	Standard	Application Received:	04/15/2015

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: Emergency 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 34 year old male, who sustained an industrial injury on 6/21/14. The injured worker was diagnosed as having right shoulder pain and dysfunction, right shoulder full thickness rotator cuff tear, right shoulder impingement, right shoulder AC joint arthrosis, right shoulder partial biceps tendon tear, cervical spine sprain/strain with muscle spasm and cervicogenic headaches and lumbar spine sprain/strain with right lower extremity lumbar radiculopathy. Treatment to date has included right shoulder arthroscopic surgery, activity restrictions, physical therapy, home exercise program and oral medications. Currently, the injured worker complains of neck pain and stiffness 7-8/10; low back pain 7-8/10 with radiation to right lower extremity and right knee pain 8/10 with popping, locking and weakness. Physical exam noted right knee with anterior laxity compared to left knee, tenderness to palpation is noted of medial and lateral joint lines and no crepitus is noted. The treatment plan included continuation of home exercise program, follow up appointment, urine toxicology, knee brace and Tramadol.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy, twice to thrice weekly for six weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Complaints, Physical Therapy.

Decision rationale: The requested Physical therapy, twice to thrice weekly for six weeks, is not medically necessary. CA MTUS, ACOEM 2nd Edition, 2004, Chapter 12, Low Back Complaints, Page 300 and Official Disability Guidelines, Low Back Complaints, Physical Therapy, recommend continued physical therapy with documented derived functional benefit. The injured worker has neck pain and stiffness 7-8/10; low back pain 7-8/10 with radiation to right lower extremity and right knee pain 8/10 with popping, locking and weakness. Physical exam noted right knee with anterior laxity compared to left knee, tenderness to palpation is noted of medial and lateral joint lines and no crepitus is noted. The treating physician has not documented sufficient objective evidence of derived functional benefit from completed physical therapy sessions. The criteria noted above not having been met, Physical therapy, twice to thrice weekly for six weeks is not medically necessary.

Range of Motion: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Flexibility Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Range of motion testing, Page 48 Page(s): 48. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back- Lumbar & Thoracic(Acute & Chronic), Flexibility.

Decision rationale: The requested Range of Motion is not medically necessary. Chronic Pain Medical Treatment Guidelines, Functional Improvement Measures, Page 48, note that such measures are recommended. However, Official Disability Guidelines (ODG), Low Back- Lumbar & Thoracic (Acute & Chronic), Flexibility, note that computerized range of motion testing Not recommended as a primary criteria, but should be a part of a routine musculoskeletal evaluation. The relation between lumbar range of motion measures and functional ability is weak or nonexistent and an inclinometer is the preferred device for obtaining accurate, reproducible measurements in a simple, practical and inexpensive way (p 400). They do not recommend computerized measures of lumbar spine range of motion which can be done with inclinometers, and where the result (range of motion) is of unclear therapeutic value. The injured worker has neck pain and stiffness 7-8/10; low back pain 7-8/10 with radiation to right lower extremity and right knee pain 8/10 with popping, locking and weakness. Physical exam noted right knee with anterior laxity compared to left knee, tenderness to palpation is noted of medial and lateral joint lines and no crepitus is noted. The treating physician has not documented exceptional circumstances to establish the medical necessity for this testing as an outlier to referenced guideline negative recommendations. The criteria noted above not having been met, Range of Motion is not medically necessary.

Follow-up with [REDACTED] for LESI: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pg. 46, Epidural steroid injections (ESIs) Page(s): 46.

Decision rationale: The requested Follow-up with [REDACTED] for LESI, is not medically necessary. California's Division of Worker s Compensation Medical Treatment Utilization Schedule (MTUS), Chronic Pain Medical Treatment Guidelines, Pg. 46, Epidural steroid injections (ESIs), recommend an epidural injection with documentation of persistent radicular pain and physical exam and diagnostic study confirmation of radiculopathy, after failed therapy trials. The injured worker has neck pain and stiffness 7-8/10; low back pain 7-8/10 with radiation to right lower extremity and right knee pain 8/10 with popping, locking and weakness. Physical exam noted right knee with anterior laxity compared to left knee, tenderness to palpation is noted of medial and lateral joint lines and no crepitus is noted. The treating physician has not documented exam or diagnostic evidence of radiculopathy. The criteria noted above not having been met, Follow-up with [REDACTED] for LESI is not medically necessary.