

Case Number:	CM14-0137086		
Date Assigned:	09/05/2014	Date of Injury:	06/01/2005
Decision Date:	10/08/2014	UR Denial Date:	08/15/2014
Priority:	Standard	Application Received:	08/25/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 35 year-old male who reported a work related injury on 06/01/2005. The mechanism of injury was not provided for review, but he was noted to have resultant musculoskeletal injuries and work-related psychological stressors. The diagnoses consisted of lumbosacral musculoligamentous sprain/strain with attendant left lower extremity radiculitis, depression, stress, and headaches. His prior treatment was not specified, but it was noted that he takes medications. The injured worker's diagnostic and surgical history was not provided for review. During a psychological evaluation on 05/02/2014, the injured worker stated he had difficulty falling asleep due to stress and was occasionally woken by nightmares. He also complained of low back pain which he rated as 1 to 4/10 on a daily basis, and occasionally the pain flared up and was an 8/10. The injured worker also complained of neck stiffness and soreness. The mental status examination revealed no physical abnormalities, such as pain related behaviors, unsteadiness, rigidity, or unusual gait. The injured worker's mood appeared to be mildly anxious. A clinical note with physical examination findings related to his musculoskeletal condition was not provided. The injured worker's prescribed medications consisted of Metoprolol for heart palpitations, Tylenol with Codeine #3 as needed, and Lorazepam for sleep disturbance. Requests were received for an ultrasound of the right shoulder, Sonata, and physical therapy. The rationale for the request and the request for authorization form were not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy; eight (8) sessions (2x4): Upheld

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

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

Decision rationale: The California MTUS Guidelines state up to 10 visits of physical therapy may be supported to promote functional gains in injured workers with unspecified radiculitis. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. In regards to the injured worker, there was not enough documentation provided to determine the medical necessity of physical therapy. In order to determine if physical therapy is needed, documentation outlining strength and range of motion deficits, as well as details regarding his treatment history and previous physical therapy, would need to be reviewed. Based on the lack of documentation, the request is not supported. Therefore, the request for physical therapy; eight (8) sessions (2x4) is not medically necessary.

Sonata 10mg #30: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Insomnia treatment.

Decision rationale: The request for Sonata 10mg is not medically necessary. Sonata is used to treat insomnia. The Official Disability Guidelines state, pharmacological agents for insomnia should only be used after careful evaluation of potential causes of sleep disturbance. Failure of sleep disturbance to resolve in a 7 to 10 day period may indicate a psychiatric and/or medical illness. Primary insomnia is generally addressed pharmacologically. Secondary insomnia may be treated with pharmacological and/or psychological measures. The specific component of insomnia should be addressed: such as sleep onset; sleep maintenance; sleep quality; and next-day functioning. Sonata is classified as a non-benzodiazepine sedative-hypnotic which is a first-line medication for insomnia. However, Sonata is indicated for short term use (7-10 days) to treat insomnia. The documentation provided does show sleep disturbances such as difficulty falling asleep due to stress and occasional nightmares. However, the medical documentation provided does not document previous treatment and testing for insomnia, efficacy, frequency, and duration of this medication. Therefore, the request for Sonata 10mg is not medically necessary. The request for #30 also exceeds the guideline recommendations of 7-10 days. As such, the request is not medically necessary.

Diagnostic ultrasound of the right shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder Chapter, Ultrasound, Diagnostic

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209.

Decision rationale: The request for a diagnostic ultrasound of the right shoulder is not medically necessary. The California MTUS/ACOEM Guidelines state for most patients with shoulder problems, special studies are not needed unless a four- to six-week period of conservative care and observation fails to improve symptoms. Most patients improve quickly, provided red-flag conditions are ruled out. The primary criteria for ordering imaging studies are: emergence of a red flag, physiologic evidence of tissue insult or neurovascular dysfunction, failure to progress in a strengthening program intended to avoid surgery, and clarification of the anatomy prior to an invasive procedure. The documentation provided did not include a musculoskeletal examination or evidence of any red flag indications, specific tissue insult, or failure to progress in a strengthening program. The documentation does not establish the necessity of a diagnostic ultrasound of the right shoulder. As such, the request for diagnostic ultrasound of the right shoulder is not medically necessary.