

Case Number:	CM14-0158749		
Date Assigned:	10/02/2014	Date of Injury:	11/20/2012
Decision Date:	11/20/2014	UR Denial Date:	09/22/2014
Priority:	Standard	Application Received:	09/28/2014

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, Spinal Cord Injury and is licensed to practice in New York. 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 56-year-old female who reported injury on 11/20/2012. The mechanism of injury was the injured worker was sorting go backs and felt pain in bilateral hands, arms, shoulders, and back. The prior therapy included physical therapy. The injured worker underwent a fusion in 2013. The injured worker underwent an MRI of the right shoulder. The injured worker underwent nerve conduction studies on 02/07/2014 and an MRI of the right shoulder and cervical spine. The injured worker underwent x-rays. The most recent documentation submitted for review was dated 05/28/2014. The injured worker was noted to undergo an anterior cervical discectomy and fusion at C5-6 and C6-7. The injured worker had persistent neck, right shoulder and right upper extremity radicular pain. The injured worker's shoulder pain was sharp, nagging and shooting. The neck and right upper extremity pain was similar to the discomfort prior to surgery. The injured worker's medications included atenolol 25 mg daily, simvastatin 40 mg daily and fluoxetine 20 mg daily. The physical examination revealed the injured worker had full range of motion. The injured worker had suprascapular discomfort on the right when the cervical spine was palpated. The injured worker had no decreased range of motion. There was no evidence of pain or radiating pain to the upper extremities on cervical motion. The Spurling's test was negative. The examination of the right shoulder revealed tenderness at the AC joint, long head of the biceps and bursitis along the lateral head of the humerus. There was decreased sensitivity to pinprick of the right upper extremity in the C6 dermatome right compared to left. The strength was 5/5. The reflexes in the biceps, triceps and brachioradialis were 1+ on the right and 2+ on the left. The diagnoses included right shoulder discomfort with subacromial impingement and right C4-5 neural foraminal stenosis and severe right C5-6 neural foraminal stenosis with radiculopathy. The treatment plan included the physician opined the injured worker would benefit from a

subacromial injection and possibly a transforaminal epidural steroid injection. There was no request for authorization or rationale submitted for the requested therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient physical therapy two times a week for four weeks for the neck, upper back and right extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Physical therapy, Neck

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

Decision rationale: The California MTUS Guidelines recommend physical medicine treatment for myalgia and myositis for up to 10 visits. The clinical documentation submitted for review failed to provide documentation of prior treatments. There was a lack of documentation indicating objective functional deficits to support the necessity for outpatient physical therapy. Additionally, there was no physician documentation or rationale for the requested intervention. Given the above, the request for outpatient physical therapy two times a week for four weeks for the neck, upper back and right extremity is not medically necessary.