

Case Number:	CM14-0173575		
Date Assigned:	10/24/2014	Date of Injury:	09/09/2010
Decision Date:	12/03/2014	UR Denial Date:	10/06/2014
Priority:	Standard	Application Received:	10/21/2014

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 Family Medicine 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:

This is a 62 year old male patient who sustained a work related injury on 09/09/2010. He had history of cut in his left forearm on a screen at work several years ago-around 2003. Patient sustained the injury due to repetitive and cumulative work. The current diagnoses include status post labral repair, rotator cuff repair, and decompression, chronic cervical pain; right shoulder impingement; bilateral carpal tunnel syndrome; cubital tunnel syndrome on left; bilateral internal derangement of knees; depression; sleep disorder; headaches; hypertension; diabetes; GERD; erectile dysfunction and s/p right and left C5-C6 and right: C7-T1 medical branch block on 4/10/14; and radiofrequency on 8/28/14. Per the doctor's note dated 9/2/14, patient has complaints of depression, sleep disorder, headaches hypertension, diabetes, GERD and erectile dysfunction that he attributes to sensory problems. He had standing and walking capacity of 30 minutes maybe quarter of mile walking. He was lifting 35 pounds, no more than 100 pounds. Physical examination revealed full motion in right shoulder, some improvement in his left shoulder after injection, May 2014, tenderness along the wrist, and positive Tinel's sign at both wrists. Per the doctor's note dated 9/24/14 patient had complaints of flare of bilateral neck pain at 7-8/10. Physical examination revealed tenderness upon palpation of cervical paraspinal muscles overlying bilateral C5-C6, C6-C7, C 7-T1, bilateral shoulders, knees, wrists and left elbow, cervical ranges of motion was restricted by pain in all directions, cervical extension was worse than cervical flexion. The current medication lists include Norco, Flexeril, Wellbutrin, Trazodone, Prilosec, Terocin cream and Medrox patches, Metformin, Bupropion, Tramadol, Hydrocodone, Loratadine, Lisinopril, and Colace. The patient has had an ultrasound , baseline liver tests; on 05/09/13 MRI of the right shoulder that revealed postoperative changes at the superolateral humeral head, extensive fraying of the distal fibers of the supraspinatus with tendinopathy; MRI of the right knee on 3/12/13 that revealed showed fissuring of articular

cartilage at medial joint compartment with marginal osteophytes, small joint effusion; MRI of the cervical spine on 10/28/13 that revealed disc bulging measuring 3 mm with moderate bilateral foraminal narrowing; EMG on 10/23/13 that revealed L5-S1 radiculopathy in lower extremity and bilateral carpal tunnel syndrome (CTS) in upper extremity. The past medical histories include hypertension, diabetes mellitus, hepatitis C, and tuberculosis. The patient's surgical history include status post right shoulder labral repair, rotator cuff repair, and decompression on March 11, 2013 and 9/13; medial branch block on 4/10/14; and radiofrequency on 8/28/14; C5-C6 and right: C7-T1 facet joint medial branch block and left C5-C6 and left C7-T1 facet joint medial branch block and left knee surgery. The patient has had left shoulder injection in May 2014 and injections to bilateral knees with no improvement. The patient has received an unspecified number of the physical therapy (PT) visits for this injury.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy, cervical spine QTY: 6: Upheld

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

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

Decision rationale: The guidelines cited below state, "allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home physical medicine." Patient has received an unspecified number of PT visits for this injury. Previous conservative therapy notes were not specified in the records provided. The requested additional visits in addition to the previously certified PT sessions are more than recommended by the cited criteria. The records submitted contain no accompanying current PT evaluation for this patient. There was no evidence of ongoing significant progressive functional improvement from the previous PT visits that is documented in the records provided. Previous PT visits notes were not specified in the records provided. Per the guidelines cited, "Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels." A valid rationale as to why remaining rehabilitation cannot be accomplished in the context of an independent exercise program is not specified in the records provided. The request for Physical Therapy, cervical spine QTY: 6 are not fully established for this patient. Therefore, the request is not medically necessary and appropriate.