

Case Number:	CM14-0063507		
Date Assigned:	07/11/2014	Date of Injury:	01/31/2006
Decision Date:	09/17/2014	UR Denial Date:	04/29/2014
Priority:	Standard	Application Received:	05/06/2014

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 & Rehabilitation and Pain 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:

The injured worker is a 53-year-old female with a reported date of injury on 07/31/2008. The mechanism of injury was not submitted within the medical records. Her diagnoses were noted to include post laminectomy syndrome to the cervical region, cervical radiculitis, bilateral upper trapezius spasm, rotator cuff tear, adjustment disorder with anxiety/depression, therapeutic medicine monitor, and long term use of medications. Her previous treatments were noted to include surgery, physical therapy, and medications. The progress note dated 04/16/2014 revealed the injured worker complained of worse neck pain and spasming, that caused increased frequency and intensity of her headaches. The injured worker indicated the symptoms had been aggravated since her shoulder surgery in January. The injured worker described the pain management regimen had been effective and increased her tolerance to perform simple activities of daily living. The injured worker reported difficulty falling asleep and staying asleep due to neck pain, and was managed by sleep aide. The injured worker continued to experience increased neck spasms throughout the day which were issues related to her initial cervical injury, which were alleviated by Soma. The psychological examination revealed the injured worker to be anxious and apprehensive due to persistent neck and increased pain in her right shoulder. The physical examination of the right shoulder revealed healing surgical sites without excessive redness or swelling. The cervical spine continued with limited flexion and extension, lateral bending and rotation. The sensations were impaired to light touch and temperature in the right thumb and index fingers. The motor strength examination continued with decreased grip strength and there was tenderness to palpation noted at the paraspinal muscles C4 to C6 bilaterally. There was persistent tenderness to palpation of the sub occipital ridges bilaterally. The progress note dated 04/22/2014 revealed that the injured worker complained of pain that radiated to her neck and into her arm with numbness and tingling rated 6/10. The injured worker

noted an increase in her range of motion. The injured worker indicated she had been unable to start physical therapy due to pain, and had increased stress due to difficulty in obtaining chronic pain medications. The physical examination noted decreased range of motion to the right shoulder with forward flexion 240 degrees and abduction 130 degrees, and a mildly positive Neer's and Hawkins' sign. The muscle strength was rated 5/5 with resisted external rotation, adduction, and abduction, 4/5 with full can testing and 4+/5 with resisted liftoff maneuver. The Request for Authorization form was not submitted within the medical records. The request was for phase 3 physical therapy, twice weekly for 6 weeks postoperatively, and a psychologist treatment referral for adjustment disorder with anxiety/depression.

IMR ISSUES, DECISIONS AND RATIONALES

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

Phase 3 physical therapy, twice weekly for 6 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27.

Decision rationale: The request for phase 3 physical therapy, twice weekly for 6 weeks is not medically necessary. The injured worker had surgery 01/2014 to the right shoulder. The postsurgical treatment guidelines for rotator cuff syndrome recommend postsurgical treatment for arthroscopic to be 24 visits over 14 weeks and the postsurgical physical medicine treatment period of 6 months. The most recent progress note indicated the injured worker had not started physical therapy due to pain, and there is lack of documentation regarding previous physical therapy sessions attended, how many and quantifiable objective functional improvements with previous physical therapy sessions. There is a lack of documentation regarding current measureable objective functional deficits and how many postsurgical physical therapy sessions have been completed. Therefore, the request is not medically necessary.

Psychologist treatment referral: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Behavioral Interventions Page(s): 23. Decision based on Non-MTUS Citation Official Disability Guidelines, Cognitive Behavioral guidelines for Chronic Pain.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 398-404.

Decision rationale: The request for referral to psychiatrist is not medically necessary. California MTUS/ACOEM states specialty referral may be necessary when injured workers have significant psychopathology or serious medical comorbidities. Segmental illnesses are chronic conditions, so establishing a good working relationship with an injured worker may facilitate a referral or the return to work process. It is recognized that primary care physician and other non-psychological specialists commonly deal with and try to treat psychiatric conditions. It is

recommended that serious conditions such as severe depression and schizophrenia be referred to a specialist while common psychiatric conditions, such as mild depression, are referred to a specialist after symptoms continue for more than 6 to 8 weeks. The practitioner can use his or her best professional judgment in determining the type of specialist. Injured workers with more serious conditions may need a referral to a psychiatrist for medical therapy. The included medical documentation lacks evidence of significant deficits related to the injured worker's mental health. There is a lack of documentation regarding previous psychiatric sessions in regards to evaluation, diagnosis, and treatment. Therefore, the request is not medically necessary.