

Case Number:	CM14-0092426		
Date Assigned:	07/25/2014	Date of Injury:	10/12/2011
Decision Date:	09/30/2014	UR Denial Date:	06/11/2014
Priority:	Standard	Application Received:	06/18/2014

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 is licensed to practice in Nevada. 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 43-year-old male who was reportedly injured on October 12, 2011. The mechanism of injury was not listed in these records reviewed. The most recent progress note dated May 23, 2014, indicated that there were ongoing complaints of neck pain with right upper extremity involvement. Also noted was low back pain with lower extremity involvement. The physical examination demonstrated a decrease in cervical spine range of motion, tenderness to palpation and some muscle spasm. Also noted was a decrease in lumbar spine range of motion associated with pain, with facet loading. Straight leg raising was reported as positive. No deformities noted with the right shoulder assessment. A slight decrease in range of motion was reported. Diagnostic imaging studies objectified degenerative disc disease at multiple levels. Electrodiagnostic studies reportedly noted a radiculopathy. A right shoulder surgery has also been completed. Previous treatment included psychiatric care, chiropractic care, multiple medications, pain management interventions and injection therapies. A request had been made for additional physical therapy and right shoulder injection and was not certified in the pre-authorization process on June 11, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

6 Sessions of Physical Therapy for the Low Back: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability

Guidelines (ODG-TWC): Physical Medicine Guidelines, Lumbar Physical Therapy; Hayden, 2005; Zigenfus, 2000.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004): Low Back Disorders-Clinical Measures-Allied Health Interventions (Electronically Cited).

Decision rationale: When noting the date of injury, the injury sustained, the finding on physical examination and the minimal changes noted on enhanced imaging studies, there is no data presented to support the medical necessity for continuing physical therapy. As outlined in the guidelines, after several sessions, transition to home exercise protocol is all that would be supported. As such, there is no clinical indication or medical necessity for this request. The request is not medically necessary and appropriate.

6 Sessions of Physical Therapy for the Right Wrist: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG-TWC): Physical Medicine Guidelines, Hand, Wrist; Handoll-Cochrane, 2003; Handoll2-Cochrane, 2003.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

Decision rationale: Physical therapy is supported for certain specific diagnoses. However, when noting the date of injury, the injury sustained, the lack of any significant improvement, there is no noted efficacy with this intervention. Therefore, based on the clinical information presented in the progress notes reviewed, medical necessity has not been established. The request is not medically necessary and appropriate.

6 Sessions of Physical Therapy for the Neck: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG-TWC): Physical Medicine Guidelines, Neck; Rosenfeld, 2000; Bigos, 1999.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174.

Decision rationale: As outlined in the guidelines, after one or 2 sessions of physical therapy, transition to home exercise protocol is although to be supported. Given the date of injury, the findings of physical examination, this is all that would be clinically indicated. Therefore the request is not medically necessary and appropriate.

6 Sessions of Physical Therapy for the Right Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG-TWC): Physical Medicine Guidelines, Shoulder; Hay, 2003; Skedros, 2007.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004): Shoulder chapter (electronically cited).

Decision rationale: When noting the date of injury, the injury sustained, and the findings on physical examination, there is no clinical indication presented for additional physical therapy. As such, the medical necessity has not been established. Therefore the request is not medically necessary and appropriate.

Right Shoulder Injection: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Shoulder, Steroid Injections; Burbank, 2008; Bloom, 2012.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004): Shoulder disorders (electronically cited).

Decision rationale: Official Disability Guidelines support steroid injections for specific diagnoses: Adhesive capsulitis, impingement syndrome and rotator cuff problems, except for post-traumatic impingement of the shoulder. Review of the available medical records, fails to document conservative treatment to include a trial of anti-inflammatories or physical therapy. As such, the request is not considered medically necessary.