

Case Number:	CM14-0164502		
Date Assigned:	10/09/2014	Date of Injury:	01/28/2010
Decision Date:	01/08/2015	UR Denial Date:	09/29/2014
Priority:	Standard	Application Received:	10/06/2014

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 Preventive Occupational Medicine and is licensed to practice in New York, New Hampshire & Massachusetts. 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 55-year-old male who reported an injury on 01/28/2010 due to an unspecified mechanism of injury. On 08/13/2014, he reported severe back pain post reconstruction for myelomeningocele and sensation of instability in the right shoulder. A physical examination of the upper extremity showed positive apprehension in the right shoulder on external rotation. Examination of the lumbar spine showed that the low back demonstrated diffuse tenderness and no evidence of recurrence of myelomeningocele. There was a healed incision and limited range of motion. He underwent an MRI of the lumbar spine on 04/15/2014 and lumbar spine surgery on 02/24/2014. Information regarding the injured worker's medications was not provided for review. He was diagnosed with status post myelomeningocele repair at [REDACTED], status post lumbar decompressed surgery, and right shoulder instability. The treatment plan was for a TENS unit, home health, pain management, and physical therapy. The Request for Authorization and rationale for treatment were not provided for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pain Management Consult: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Chapter 7 Independent Medical Examinations and Consultations

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

Decision rationale: The Official Disability Guidelines state that the need for a clinical office visit with a healthcare provider is individualized based upon a review of the injured worker's concerns, signs and symptoms, and clinical stability. Based on the clinical information submitted for review, the injured worker was noted to be symptomatic regarding the upper extremity and lumbar spine. However, there is a lack of documentation showing evidence that would indicate the need for a pain management consultation. In addition, a clear rationale for the medical necessity of a pain management consultation was not provided for review. Furthermore, there was no recent documentation submitted for review regarding the injured worker's current medical status and therefore, the request would not be supported. Given the above, the request is not medically necessary.

Physical therapy for right shoulder 3x week x 6 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain 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 that physical therapy is recommended for 9 to 10 visits over 8 weeks for myalgia and myositis unspecified. For neuralgia, neuritis, and radiculitis unspecified, 8 to 10 visits over 4 weeks is recommended. Based on the clinical information submitted for review, the injured worker was noted to be symptomatic regarding the lumbar spine and right upper extremity. However, there is a lack of documentation showing evidence of significant functional deficits that would indicate the need for physical therapy treatment. In addition, the number of sessions being requested exceeds the guideline recommendations. There were no exceptional factors noted to support exceeding the guidelines and therefore, physical therapy treatment would not be supported. Given the above, the request is not medically necessary.