

Case Number:	CM15-0003911		
Date Assigned:	01/14/2015	Date of Injury:	02/04/2013
Decision Date:	03/13/2015	UR Denial Date:	12/31/2014
Priority:	Standard	Application Received:	01/07/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: New Jersey, New York
 Certification(s)/Specialty: Family Practice

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 female with an industrial injury dated 02/04/2013. Her diagnoses include small cervical disc herniation at C3-C4, lumbar spine disc herniation at L3-S1, bilateral elbow and wrist sprains, bilateral carpal tunnel syndrome, bilateral knee strains, bilateral shoulder strains, left ankle sprain, post-traumatic stress disorder, and thoracic strain. Diagnostic testing has included a MRI of the left shoulder revealing a moderate degree of fluid in the subacromial bursa compatible with subacromial bursitis with supraspinatus tendinosis and reactive pertendinitis, and a MRI of the right shoulder revealing a moderate amount of fluid in the subacromial bursa compatible with subacromial bursitis with supraspinatus tendinosis and reactive pertendinitis. She has been treated with vestibular physical therapy, chiropractic therapy, physical therapy, and psychotherapy treatments. In a progress note dated 11/04/2014, the treating physician did not report any subjective findings as reported by the injured worker, and there were no objective findings in regards to the bilateral shoulders. The treatment plan stated to continue with authorized vestibular therapies with a request for 6 additional vestibular and vision therapy sessions, a right shoulder arthroscopy and subacromial decompression which was previously denied, and Gabapentin 300 mg at bedtime. A physical therapy evaluation (09/08/2014) reported that the injured worker described symptoms of left-sided hearing loss, dizziness, cervical pain, blurred vision, double vision with up-close objects, and headaches that are aggravated by movement. The objective findings included decreased cervical range of motion, abnormal dizziness handicap inventory test, and abnormal findings on a visual analog scale, sensory organization test, and neck disability index. The assessment findings were reported to be

consistent with post-concussive syndrome and it was recommended that the injured worker would benefit from vestibular physical therapy. The treating physician is requesting psych evaluation and treatment, physical therapy for the shoulders and additional vestibular therapy which have been denied by the utilization review. On 12/31/2014, Utilization Review non-certified a request for psych evaluation and treatment for psychotropic medications for a 16 week trial, noting the absence of psychological complaints and clinical testing, and unclear documentation in regards to previous psychological evaluations and treatments. The MTUS, ACOEM Guidelines, and ODG were cited. On 12/31/2014, Utilization Review non-certified a request for 6 sessions of physical therapy to the bilateral shoulders, noting the absence of documented functional improvement with the previous physical therapy treatments and the number of treatments received. The MTUS, ACOEM and ODG were cited. On 12/31/2014, Utilization Review non-certified a request for 6 additional vestibular and vision therapy sessions, noting the absence of the number of previous sessions received, the absence of functional improvement, and the absence of specific examination findings. The ODG was cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Psych evaluation and treatment for psychotropic medications for a 16 week trial: 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 Examination and Consultations (pp127,156) Official Disability Guidelines (ODG) Pain Chapter

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines psychological evaluation, psychological treatment Page(s): 100-102.

Decision rationale: The request is considered not medically necessary due to lack of appropriate documentation. Psychiatric evaluation and treatment are recommended for patients with mood disorders and chronic pain. An AME report was noted to have diagnosed the patient with mood disorder but was not included in the chart. It is unclear in the chart if the patient had prior psychotherapy and treatment and if there was improvement afterwards. Therefore, at this time, the request is considered not medically necessary.

6 sessions of Physical Therapy to bilateral shoulders: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation Page(s): 114, 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 request for more physical therapy is not medically necessary. The patient has already had an unknown amount of physical therapy sessions. As per MTUS guidelines, patients are "expected to continue active therapies at home as an extension of the

treatment process in order to maintain improvement levels." The recommended number of sessions for myalgias is 9-10 visits over 8 weeks, and for radiculitis is 8-10 visits over 4 weeks. She currently has no red flags or objective progressive deficits of her shoulder that would require more supervised physical therapy. She should be continuing a home exercise program at this point. The patient is also recommended to have surgery so additional physical therapy may not be beneficial. Therefore, this request is considered not medically necessary.

Additional 6 sessions of vestibular and vision therapy: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Head Chapter

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation vestibular PT rehabilitation--head

Decision rationale: The request is considered not medically necessary. The patient has had rehab before but without documentation of number of sessions. An additional six sessions had been authorized but there was no documentation that these had been done or if there was any improvement in symptoms or functional capacity. Therefore, the request is considered not medically necessary due to lack of documentation.