

Case Number:	CM15-0142063		
Date Assigned:	07/31/2015	Date of Injury:	11/03/2010
Decision Date:	08/28/2015	UR Denial Date:	06/22/2015
Priority:	Standard	Application Received:	07/22/2015

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 65-year-old female who sustained an industrial injury on November 3, 2010 resulting in headache and neck pain radiating to the right shoulder. She was diagnosed with cervical spondylosis, limb pain, shoulder joint pain, cervicgia, muscle spasm, and cervicogenic migraine headache. Treatment has included medication, physical therapy, BOTOX injections for headache, Egoscue treatment with reported improvement in shoulder pain, home exercise, and medication. The injured worker continues to report burning pain in the left side of her neck, which spreads to her left shoulder. The treating physician's plan of care includes 6 additional Egoscue sessions for the right shoulder. Her current work status is not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Egoscue for the right shoulder qty. 6: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chronic Pain Treatment Guidelines Physical Medicine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Therapy, pages 98-99.

Decision rationale: Therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. However, there is no clear measurable evidence of progress with the Egoscue therapy treatment already rendered including milestones of increased ROM, strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints, clinical findings, and functional status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. The Chronic Pain Guidelines allow for visits of therapy with fading of treatment to an independent self-directed home program. It appears the employee has received significant therapy sessions without demonstrated evidence of functional improvement to allow for additional therapy treatments. There is no report of acute flare-up, new injuries, or change in symptom or clinical findings to support for formal therapy in a patient that has been instructed on a home exercise program for this chronic 2010 injury. Submitted reports have not adequately demonstrated the indication to support further therapy when prior treatment rendered has not resulted in any functional benefit. The Egoscue for the right shoulder qty. 6 is not medically necessary and appropriate.