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| Case Number: | CM15-0213558 | | |
| Date Assigned: | 11/03/2015 | Date of Injury: | 06/17/2013 |
| Decision Date: | 12/15/2015 | UR Denial Date: | 10/15/2015 |
| Priority: | Standard | Application Received: | 10/30/2015 |

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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 46 year old male who sustained an industrial injury on 6-17-2013. A review of medical records indicates the injured worker is being treated for pain in the left shoulder and other spondylosis with myelopathy, cervical region. Medical records dated 10-1-2015 noted he continues with left lateral neck and left shoulder pain radiating to the left arm. Physical examination noted left shoulder range of motion was moderate pain with motion. Left elbow range of motion had moderate pain with motion. Left hand had moderate pain with motion. Treatment has included Endocet since at least 3-13-2015. Utilization review form noncertified physical therapy 2 x a week x 6 weeks neck, left shoulder, left elbow, and head.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 2 times a week times 6 weeks, for the neck, left shoulder, left elbow, and head: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, and Shoulder Complaints 2004, and Elbow Complaints 2007. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper back (Acute and Chronic); Shoulder (Acute and Chronic); Elbow (Acute and Chronic) Head; Physical therapy (PT).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (1) Chronic pain, Physical medicine treatment. (2) Preface, Physical Therapy Guidelines.

Decision rationale: The claimant sustained a work injury in June 2013 when, while working as Maintenance Director, he developed left neck and upper extremity pain. Electrodiagnostic testing in October 2013 showed bilateral carpal tunnel syndrome and left-sided cervical radiculopathy. He underwent an epidural injection in July 2014. When seen in October 2015 he was continuing to have left lateral neck pain. He was having left shoulder pain radiating to the arm. There had been a 30-pound weight gain since his injury. Physical examination findings included a body mass index of nearly 38. He had left shoulder, elbow, and hand pain with range of motion. There was decreased bilateral shoulder range of motion. Authorization is being requested for 12 sessions of physical therapy. The claimant is being treated for chronic pain with no new injury. In terms of physical therapy treatment for chronic pain, guidelines recommend a six visit clinical trial with a formal reassessment prior to continuing therapy. In this case, the number of visits requested is in excess of that recommended or what might be needed to determine whether continuation of physical therapy was needed or likely to be effective. For this reason, the request is not considered medically necessary.