

Case Number:	CM14-0116084		
Date Assigned:	08/04/2014	Date of Injury:	12/08/2011
Decision Date:	10/14/2014	UR Denial Date:	07/01/2014
Priority:	Standard	Application Received:	07/24/2014

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 Internal Medicine, has a subspecialty in Pulmonary Diseases and is licensed to practice in California. 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 51-year-old female who reported an injury on 12/08/2011. The mechanism of injury was not provided. On 08/05/2014, the injured worker presented with back, shoulder, and left hand and wrist pain. Upon examination of the cervical spine, the left shoulder is down 1.5 cm as compared to the right, with slight concavity to the right. There is moderate tenderness in the paracervical musculature bilaterally and in the trapezius. Extension and rotation on either side causes right junction discomfort. Bilateral shoulder examination demonstrated tenderness in the bicipital groove that radiated into the coracoid bilaterally, and into the lateral tuberosity and lateral aspect of the supraspinatus fossa. The range of motion values were 120 degrees of flexion, 40/50 degrees of extension, 60/50 degrees of extended rotation and abduction, and external rotation was 90/90 to the right, and 90/70 to the left. Diagnoses were sprain/strain of the neck, unspecified disorder of the bursae tendon shoulder, sprain/strain of the wrist unspecified, brachial neuritis/radiculitis other, and chronic pain syndrome. The provider recommended physical therapy for the cervicobrachial syndrome and behavioral pain management weekly for 8 weeks. The provider's rationale was not provided. The Request for Authorization form was not included in the medical documents for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy for cervicobrachial syndrome #1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98.

Decision rationale: The request for Physical Therapy for cervicobrachial syndrome #1 is not medically necessary. The California MTUS Guidelines state that active therapy is based on the philosophy that therapeutic exercise and activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. Injured workers are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. There is lack of documentation indicating the injured worker's prior courses of physical therapy, as well as efficacy of those treatments. Additionally, the amount of physical therapy visits the injured worker underwent was not provided. The guidelines recommend 10 visits of physical therapy for up to 4 weeks. There are no significant barriers to transitioning the injured worker to an independent home exercise program. The amount of physical therapy visits being requested by the provider was not submitted. Therefore, based on all of the above, the request is not medically necessary.

Behavioral pain management weekly for 8 weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ODG Cognitive Behavior Therapy guidelines for chronic pain Page(s): 23.

Decision rationale: The request for Behavioral pain management weekly for 8 weeks is not medically necessary. The California MTUS Guidelines recommend a psychotherapy referral after a 4 week lack of progress in physical medicine alone. An initial of 3 to 4 psychotherapy visits over 2 weeks would be recommended, and with evidence of objective functional improvement, a total of up to 6 to 10 visits over 5 to 6 weeks would be recommended. The requesting physician did not include an adequate psychological assessment, including quantifiable data in order to demonstrate significant deficits, which would require therapy as well as establish a baseline that by which to assess the efficacy of the previous therapy sessions. The provider's request does not indicate the amount of visits being requested in the request as submitted. As such, medical necessity has not been established.