

Case Number:	CM14-0216261		
Date Assigned:	01/06/2015	Date of Injury:	07/01/2013
Decision Date:	03/03/2015	UR Denial Date:	12/04/2014
Priority:	Standard	Application Received:	12/24/2014

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. 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: Pennsylvania

Certification(s)/Specialty: Internal Medicine, Hospice & Palliative Medicine

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 38 year old male sustained an industrial related injury on 07/01/2013 when he slipped and fell on a wet and oily floor. The results of the injury included neck pain, left shoulder pain, and low back pain. The initial diagnoses were not provided. Per the progress report (PR) (10/27/2014), the injured worker's subjective complaints included worsening pain in the left shoulder with shooting pain that goes through his head and down the right upper extremity with tingling pain down the left arm. The injured worker also reported pressure pain in the lumbar spine with constant numbness in his right leg and a burning pain that feels like an electrical shock. There were no noted objective or measurable findings on this report nor in any of the recent reports. Treatment to date has included medications, physical therapy, nerve blocks, epidural steroid injections, use of a TENS unit, and diagnostic arthroscopy of the left shoulder with a biceps tendon tenodesis, acromioplasty and Mumford procedure, lysis of adhesion with subacromial bursectomy, partial synovectomy, removal of loose bodies and intra-articular injection. Diagnostic testing has included x-rays of the left shoulder and left humerus (unknown date) which showed no increase in osteoarthritis; x-ray of the cervical spine (unknown date) showing loss of cervical lordosis, MRI of the left shoulder (09/2013) with unknown results, and MRI of the low back (03/24/2014) which revealed: 1) right paracentral disc extrusion at the L4-L5 extending in a caudal manner behind the superior L5 endplate contributing to severe right lateral recess and severe acquired superimposed upon congenital stenosis and additional right paracentral L4-L5 disc protrusion; 2) right paracentral protrusion at L5-S1 causing severe right lateral recess stenosis without central canal narrowing; 3) mild degenerative disc disease at T11-

T12 and T12-L1 without evidence for associated stenosis; 4) facet arthropathy changes at L2-L3 through L4-L5. Current diagnoses include displacement of cervical intervertebral disc without myelopathy (722.0), rotator cuff (capsule) sprain (840.4), and cervicalgia (723.1). The request for authorization was not found in the clinical records submitted and there was no rationale for the requested treatments found. Treatments in place around the time the care giver services and physical therapy were requested included medications. The injured worker reported pain was increased. Functional deficits and activities of daily living were unchanged. Work status is unchanged as the injured worker remains temporarily totally disabled. Dependency on medical care was unchanged. On 12/04/2014, Utilization Review non-certified a request for care giver three (3) hours per day Monday thru Friday for three (3) weeks which was requested on 11/19/2014. The UR submitted with the clinical notes did not include the detailed report with rationale; therefore, the reason that the care giver services were non-certified is not clear. The MTUS Chronic Pain guidelines were cited. This UR decision was appealed for an Independent Medical Review. The submitted application for Independent Medical Review (IMR) requested an appeal for the non-certification of the requested care giver three (3) hours per day Monday thru Friday for three (3) weeks. On 12/04/2014, Utilization Review non-certified a request for post-operative physical therapy (PT) for the left shoulder which was requested on 11/19/2014. The UR submitted with the clinical notes did not include the detailed report with rationale; therefore, the reason that the post-operative physical therapy was non-certified is not clear. The MTUS Post-Surgical guidelines were cited. This UR decision was appealed for an Independent Medical Review. The submitted application for Independent Medical Review (IMR) requested an appeal for the non-certification of post-operative physical therapy for the left shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Care giver 3 hrs. per day, Monday thru Friday, 3 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home health services Page(s): 51.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Services Page(s): 51.

Decision rationale: The MTUS Guidelines recommend the use of home health services for those who are homebound and for a maximum of thirty-five hours per week. The worker must have a skilled need, not just require homemaker assistance. The documentation concluded the worker suffered from pain in the left shoulder, lower back, and neck. There was no discussion sufficiently detailing the worker's homebound status, unmet skilled medical needs, or special circumstances that would sufficiently support the need for these services. The request for a caregiver suggests the worker had no skilled need. For these reasons, the current request for a caregiver for three hours daily, Monday through Friday, for three weeks is not medically necessary.

Post operative physical therapy, left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

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

Decision rationale: The MTUS Guidelines support the use of physical therapy, especially active treatments, based on the philosophy of improving strength, endurance, function, and pain intensity. This type of treatment may include supervision by a therapist or medical provider. The worker is then expected to continue active therapies at home as a part of this treatment process in order to maintain the improvement level. Decreased treatment frequency over time ('fading') should be a part of the care plan for this therapy. The Guidelines support specific frequencies of treatment and numbers of sessions depending on the cause of the worker's symptoms. The request was made for an indefinite number of physical therapy sessions, which does not account for potential changes in the worker's overall health, treatment needs, or transition to a home exercise program. For these reasons, the current request for an indefinite number of post-operative physical therapy sessions for the left shoulder is not medically necessary.