

Case Number:	CM15-0073146		
Date Assigned:	04/23/2015	Date of Injury:	09/05/2007
Decision Date:	06/11/2015	UR Denial Date:	03/18/2015
Priority:	Standard	Application Received:	04/16/2015

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: Texas, California

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:

This 42-year-old woman sustained an industrial injury on 9/5/2007. The patient sustained the injury when a light diffuser fell on her. Evaluations include left shoulder MRI dated 11/12/2007, left brachial plexus MRI dated 3/12/2008, electromyogram of the bilateral upper extremities dated 3/14/2008, cervical spine MRI dated 3/21/2008, left shoulder post-injection MRI dated 6/10/2008, cervical spine and left shoulder x-rays dated 3/26/2010, and cervical spine and left shoulder MRIs dated 3/26/2010. Diagnoses include left shoulder pain, insomnia, complex regional pain syndrome of the left upper extremity, and chronic pain. Treatment has included oral medications. The worker has recently been approved for acupuncture, psychiatric consultation and orthopedic consultation, however, is awaiting appointments. Physician notes dated 2/18/2015 show complaints of neck and upper extremity pain with associated insomnia, anxiety, and depression. The pain is rated 6/10 with medications and 9/10 without medications. Recommendations include physical therapy, myofascial release therapy, Doxepin, Hydrocodone/APAP, Lyrica, Tizanidine, Aciphex, discontinue Duloxetine and Pantoprazole, and follow up in one month. The patient had received left shoulder cortisone injection. The medication list includes Lyrica, Norco, Doxepin, Duloxetine, Tizanidine, AcipHex and Lunesta. Per the doctor's note, dated 3/18/15 patient had complaints of neck pain with radiation down bilateral upper extremities, upper extremity in bilateral shoulders accompanied by numbness and insomnia, anxiety and depression. Physical examination of the left shoulder revealed tenderness on palpation and limited range of motion. Patient has received an unspecified number of PT visits for this injury.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy for the Cervical Spine, one to two times a week for four weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine.

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

Decision rationale: Request: Physical Therapy for the Cervical Spine, one to two times a week for four weeks. The guidelines cited below state, "allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home physical medicine." Patient has received an unspecified number of PT visits for this injury. Previous conservative therapy notes were not specified in the records provided. The requested additional visits in addition to the previously certified PT sessions are more than recommended by the cited criteria. The records submitted contain no accompanying current PT evaluation for this patient. There was no evidence of ongoing significant progressive functional improvement from the previous PT visits that is documented in the records provided. Previous PT visits notes were not specified in the records provided. There was no objective documented evidence of any significant functional deficits that could be benefitted with additional PT. Per the guidelines cited, "Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels." A valid rationale as to why remaining rehabilitation cannot be accomplished in the context of an independent exercise program is not specified in the records provided. The medical necessity of the request for Physical Therapy for the Cervical Spine, one to two times a week for four weeks is not fully established for this patient. Therefore, this request is not medically necessary.