

Case Number:	CM13-0008398		
Date Assigned:	09/09/2013	Date of Injury:	10/07/2011
Decision Date:	01/08/2014	UR Denial Date:	07/31/2013
Priority:	Standard	Application Received:	08/06/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation 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 physician 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.

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 underlying date of injury in this case is 10/07/2011. The primary diagnoses include 840, 727.03, 354.0, and 726.31. The treating physician's notes report the diagnoses of a right long finger active triggering and locking, history of 1993 right carpal tunnel release and de Quervain's release and right ring finger release, bilateral medial epicondylitis, bilateral forearm flexor and extensor tenosynovitis with dynamic carpal tunnel syndrome, status post left long finger trigger release, bilateral shoulder parascapular strain with impingement, and history of insomnia related to chronic pain. The patient is a 54-year-old woman whose accepted injuries include both shoulders and fingers of both hands. Other body parts have not been accepted. The patient is status post a left shoulder arthroscopy with Mumford procedure and labrum repair 05/22/2013. An initial physician reviewer concluded that a request for physical therapy should not be certified because there was insufficient documentation of why an independent home program would not be possible. The reviewer did modify the request for 2 visits. That reviewer also modified a request for chiropractic to 4 visits to the right shoulder, noting that guideline criteria were partially met. The reviewer that a home resistance chair with freedom flex shoulder stretcher was not met because this device is not customarily used to serve a medical purpose. The reviewer also recommended non-certification of home care given that documentation of home-bound status of medical necessity was not met.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy, left shoulder, #4: Upheld

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

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

Decision rationale: The Chronic Pain Medical Treatment Guidelines Section on Physical Medicine, page 98-99, recommends, "Active therapy requires an internal effort by the individual to complete a specific exercise or task...Allow for fading of treatment frequency plus active self-directed home Physical Medicine." The records do not provide a rationale as to why this patient currently requires additional supervised rather than independent rehabilitation. This request is not medically necessary.

Chiropractic/physiotherapy treatments, right shoulder, #8: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Physical Therapy.

Decision rationale: The Chronic Pain Medical Treatment Guidelines Section on Manual Therapy and Manipulation does not address treatment to the shoulder. The Official Disability Guidelines, Shoulder Chapter states regarding manipulation, "Allow for fading of treatment frequency plus active self-directed home therapy." The medical records do not provide a rationale as to why this patient requires additional chiropractic/physiotherapy rather than independent home rehabilitation at this time. This request is not medically necessary.

Purchase resistance chair with freedom flex shoulder, purchase: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee Durable Medical Equipment.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section on Exercise Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back.

Decision rationale: The Chronic Pain Medical Treatment Guidelines Section on Exercise, page 46, states, "There is no sufficient evidence to support the recommendation of any particular exercise regimen over any other exercise regimen." Additionally I note that Official Disability Guidelines/Treatment of Workers' Compensation/Low Back states regarding gym membership, "While an individual exercise program is of course recommended, more elaborate personal care or outcomes that are not monitored by a health professional, such as gym memberships or advanced home exercise equipment, may not be covered under this guideline." The records do not provide a rationale as to why this particular equipment is necessary for this patient. This request is not medically necessary.

Home care, #6 (3 days week, for 4 hours): 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 Section on Home Health Services Page(s): 51.

Decision rationale: The Chronic Pain Medical Treatment Guidelines Section on Home Health Services, page 51, states, "Recommended only for otherwise recommended medical treatment for patients who are homebound, on a part-time or intermittent basis, generally up to no more than 35 hours per week." The medical records do not support that this patient is homebound nor clarified the specific homecare needs in this case. This request is not medically necessary.