

Case Number:	CM13-0010744		
Date Assigned:	12/20/2013	Date of Injury:	08/01/2010
Decision Date:	02/28/2014	UR Denial Date:	07/18/2013
Priority:	Standard	Application Received:	08/14/2013

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 & 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. 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:

This female patient sustained an injury on 8/1/10. Request under consideration include physical therapy for the wrists and shoulders. Current diagnoses list trigger finger; radial styloid tenosynovitis; disorder of the bursae and tendon in shoulder region, unspecified. Previous treatment has included right shoulder rotator cuff repair, carpal tunnel release surgery, time off, medications, and an unspecified amount of PT. MRI of right wrist on 5/13/13 notable for post-operative changes consistent with prior CTR. MRI of the cervical spine on 5/13/13 notable for multi-level disk bulges and protrusions of uncertain clinical significance. Report of 7/10/13 from [REDACTED], ortho, noted patient has had some PT and reported some gains in range of motion in some planes but still apparently has difficulty in others. Exam was noted with 4+/5 strength. Treatment included additional PT while remaining off work on total temporary disability. Report of 8/14/13 noted residual right shoulder pain even though there has been some improvement with range of motion. Plan noted the patient for her right shoulder has reached the level of maximum medical improvement with future medical care of treatment for flare-up or exacerbation. PT request above was non-certified on 7/18/13 citing guidelines criteria and lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy for the wrists and shoulders (8 sessions): Upheld

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

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

Decision rationale: Physical therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. There is unchanged chronic symptom complaints, clinical findings, and work status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. The Chronic Pain Guidelines allow for 9-10 visits of physical therapy with fading of treatment to an independent self-directed home program. The employee has failed conservative treatment without physiologic evidence of tissue insult, neurological compromise, or red-flag findings to support treatment request. The physical therapy for the wrists and shoulders 2X4 is not medically necessary and appropriate.