MAXIMUS Federal Services

| Case Number: | CM13-0016812 | | |
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| Date Assigned: | 06/09/2014 | Date of Injury: | 10/27/2011 |
| Decision Date: | 07/30/2014 | UR Denial Date: | 08/14/2013 |
| Priority: | Standard | Application Received: | 08/26/2013 |

## 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 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 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 52-year-old male who reported an injury on 10/27/2011. The mechanism of injury is unknown. The injured worker complained of an occasional moderate throbbing headache. He also complained of a constant moderate 6/10 sharp, throbbing neck pain, stiffness, and heaviness becoming so severe as to reach up to 8/10, that radiated bilaterally to his shoulders. The injured worker had complaints of activity dependent to constant moderate 6/10 achy, throbbing, low back pain, becoming severe to 9/10, which radiated down to his bilateral legs while walking. He complained of occasional moderate 5/10 to 6/10 achy left wrist pain, which radiated to the hand and fingers with numbness and tingling. He had complaints of occasional moderate 5/10 to 6/10 achy right wrist pains, which radiated to his hands and fingers with numbness and tingling. There was a complaint of a loss of sleep due to pain. The physical examination findings revealed that the cervical range of motion was decreased. There was +3 tenderness to palpation of the cervical paravertebral muscles. There were muscle spasms of the cervical paravertebral muscles. The examination of the lumbar range of motion revealed it was decreased and painful. There was +3 tenderness to palpation of the lumbar paravertebral muscles. There were muscle spasms of the lumbar paravertebral muscles. The left wrist range of motion was decreased. There was +3 tenderness to palpation over the volar wrist. The range of motion to the right wrist was within normal limits. There was +3 tenderness to palpation of the volar wrist. The injured worker has diagnoses of headache, posttraumatic plus chronic; cervical musculoligamentous injury; cervical myofaciitis, cervical disc protrusion with annular tear and neuralforaminal narrowing; cervical radiculitis; lumbar musculoligamentous injury; lumbar myofaciitis 6 mm disc protrusion with anterolisthesis L5-S1 and neuralforaminal narrowing; lumbar S1 bilateral radiculopathy; right wrist subchondral cyst; bilateral carpal tunnel syndrome; left wrist subchondral cyst and synovial versus ganglion cyst; high blood pressure; loss of sleep

and psych component. The injured worker has undergone physical therapy and medication therapy. The medications were noted as Keflex and Norco; no duration or frequencies were noted within the submitted reports. The current treatment plan is for retro: physical therapy 2 times per week times 6 weeks for left lateral release. The request for authorization and rationale form were not submitted for review.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Retro: Physical Therapy 2 times per week for 6 weeks for Left Lateral release:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 16-17.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 17.

**Decision rationale:** The request for retro: physical therapy 2 times per week for 6 weeks for left lateral release is not medically necessary. The injured worker complained of constant 6/10 sharp, throbbing neck pain, stiffness, and heaviness. He also complained of throbbing low back pain, rated at a 9/10. The injured worker also complained of wrist pain that radiated to his hand and fingers. The California Medical Treatment Utilization Schedule (MTUS) guidelines stipulate that with Lateral epicondylitis/Tennis elbow surgery, you are allotted 12 postsurgical physical therapy session visits over 12 weeks with postsurgical physical medicine treatment period of 6 months. In the submitted report, it shows the injured worker has already completed 15 sessions of physical therapy from 04/15/2013 through 06/14/2013. The submitted report lacked documentation of subjective and objective findings. It also did not have any evidence of functional deficits that the injured worker had prior to physical therapy and after physical therapy. It also did not have any evidence of range of motion and motor strength ranging on the injured worker. Given the above, the request for retro physical therapy 2 times per week times 6 weeks for left lateral release is not medically necessary.