

Case Number:	CM13-0018566		
Date Assigned:	06/06/2014	Date of Injury:	09/27/2010
Decision Date:	07/25/2014	UR Denial Date:	08/01/2013
Priority:	Standard	Application Received:	08/30/2013

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 Orthopedic Surgery, and is licensed to practice in Texas and Colorado. 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 64-year-old female who reported an injury 09/27/2010. The mechanism of injury was not provided within the medical records. The clinical note, dated 07/19/2013, indicated the injured worker reported chronic bilateral upper extremity pain. The injured worker reported she had finished postoperative physical therapy for her left upper extremity and stated she had received benefit from the surgery and physical therapy. The injured worker reported less pain, but continued weakness. The injured worker's prior treatments included diagnostic imaging, surgery, physical therapy, and medication management. The provider submitted a request for physical therapy. A request for authorization, dated 07/25/2013, was submitted for 2 sessions a week for 6 weeks, physical therapy for left upper extremity. However, a rationale was not provided for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY 2X WEEK X 6 WEEKS-LEFT UPPER EXTREMITY: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 16, 21.

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

Decision rationale: The request for physical therapy 2x week x 6 weeks-left upper extremity is not medically necessary. The California MTUS guidelines recommend that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. Injured workers are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. There is lack of documentation including an adequate and complete physical exam demonstrating the injured worker had decreased functional ability, decreased range of motion, and decreased strength or flexibility. In addition, the completed physical therapy should have been adequate to improve functionality and transition the injured worker to a home exercise program where the injured worker may continue with exercises such as strengthening, stretching, and range of motion. Additionally, 12 additional sessions is excessive. Therefore, the request for physical therapy 2 times a week for 6 weeks to the left upper extremity is not medically necessary.