

Case Number:	CM13-0032564		
Date Assigned:	12/11/2013	Date of Injury:	08/24/2010
Decision Date:	02/06/2014	UR Denial Date:	09/11/2013
Priority:	Standard	Application Received:	10/08/2013

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 Family Practice and is licensed to practice in Texas. 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:

The patient is a 35-year-old female who reported an injury on 08/24/2010. The patient is currently diagnosed with cervical strain with right upper extremity radiculopathy, status post right shoulder arthroscopic subacromial decompression with Mumford procedure, left shoulder impingement syndrome with acromioclavicular joint pain, right greater than left wrist overuse injury, and adjustment disorder with mixed emotional features. The patient was seen by [REDACTED] on 08/08/2013. The patient reported persistent shoulder and neck pain. Physical examination revealed tenderness to palpation of the cervical spine with 40 degrees extension and tenderness about the acromioclavicular joint on the right. Treatment recommendations included physical therapy to the cervical spine and right shoulder 2 times per week for 5 weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy: ten (10) sessions, 2 times a week for 5 weeks for the cervical spine:
Upheld

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

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

Decision rationale: California MTUS guidelines state 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. Guidelines allow for fading of treatment frequency, plus active, self-directed home physical medicine. As per the clinical notes submitted, the patient has previously completed a course of physical therapy. Documentation of the previous course with treatment duration and efficacy was not provided for review. There is no evidence of significant functional limitations. The medical necessity has not been established. Therefore, the request is non-certified.

Physical therapy: ten (10) sessions 2 times a weeks for 5 weeks for the right shoulder:
Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Physical therapy

Decision rationale: California MTUS guidelines state 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. Guidelines allow for fading of treatment frequency, plus active, self-directed home physical medicine. As per the clinical notes submitted, the patient has previously completed a course of physical therapy. Documentation of the previous course with treatment duration and efficacy was not provided for review. There is no evidence of significant functional limitations. The medical necessity has not been established. Therefore, the request is non-certified.