

Case Number:	CM13-0052251		
Date Assigned:	12/27/2013	Date of Injury:	05/11/2012
Decision Date:	05/02/2014	UR Denial Date:	10/18/2013
Priority:	Standard	Application Received:	11/15/2013

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 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 26-year-old female who reported an injury on 05/11/2012. The mechanism of injury was not provided for review. The injured worker reportedly sustained injury to her right hand, neck and right shoulder. The injured worker's treatment history included activity modifications, physical therapy, medications, corticosteroid injections and immobilization. The injured worker was evaluated on 09/11/2013. Physical findings included decreased cervical spine range of motion described as 50 degrees in flexion, 60 degrees in extension, and 60 degrees in right and left lateral rotation with tenderness to palpation and tightness in the cervical paraspinal musculature. Evaluation of the right wrist revealed restricted range of motion secondary to pain with tenderness to palpation over the distal radial ulnar joint. Physical evaluation of the right shoulder revealed a positive impingement sign. The injured worker's diagnoses included bilateral carpal tunnel syndrome, cervical spine sprain/strain, right elbow sprain/strain, left elbow sprain/strain, and right shoulder strain. The injured worker's treatment plan included a cervical spine MRI to establish the presence of disc pathology, Final Determination Letter for IMR Case Number CM13-0052251 3 physical therapy 2 times a week for 6 weeks for exercise and strengthening, and an exercise kit for the upper extremity.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSIOTHERAPY TWO (2) TIMES A WEEK FOR SIX (6) WEEKS FOR THE RIGHT SHOULDER, CERVICAL SPINE AND RIGHT WRIST: Upheld

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

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

Decision rationale: The requested physiotherapy 2 times a week for 6 weeks for the right shoulder, cervical spine and right wrist are not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends that patients be transitioned into a home exercise program to maintain improvement levels obtained during skilled physical therapy. The clinical documentation submitted for review does indicate that the injured worker has previously participated in physical therapy. There are no barriers noted within the documentation to preclude further progress of the injured worker while participating in a home exercise program. However, the injured worker's most recent clinical evaluation did not provide any information regarding a home exercise program. Therefore, 1 to 2 visits of physical therapy would be appropriate for this injured worker to re-establish and re-educate the injured worker in a home exercise program. However, the requested 12 visits would be considered excessive. Additionally, California Medical Treatment Utilization Schedule recommends up to 10 visits for neuralgia and radiculitis. The requested 12 visits also exceed this recommendation. There are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. As such, the requested physiotherapy 2 times a week for 6 weeks for the right shoulder, cervical spine and right wrist are not medically necessary or appropriate.

EXERCISE KIT FOR BILATERAL UPPER EXTREMITIES: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines EXERCISE Page(s): 46-47.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Exercise Page(s): 46.

Decision rationale: The requested exercise kit for bilateral upper extremities is not medically necessary or appropriate. California Medical Treatment Utilization Schedule does not recommend 1 type of Final Determination Letter for IMR Case Number CM13-0052251 4 exercise over another. However, the clinical documentation submitted for review fails to provide any evidence that the injured worker has failed to progress through a self-directed and self-managed exercise program. There is no indication within the submitted documentation of a need for additional exercise equipment. As such, the requested exercise kit for the bilateral upper extremities is not medically necessary or appropriate.

MRI OF THE CERVICAL SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

Decision rationale: The requested MRI of the cervical spine is not medically necessary or appropriate. The Neck and Upper Back Complaints ACOEM guidelines recommend an MRI when there are clinically evident signs of radiculopathy. The clinical documentation submitted for review does not provide any objective findings of radiculopathy. There is no documentation of decreased motor strength, neurological deficits, or radiating pain. Therefore, the need for a cervical MRI is not clearly supported. As such, the requested cervical MRI is not medically necessary or appropriate.