

Case Number:	CM13-0063321		
Date Assigned:	12/30/2013	Date of Injury:	05/26/2011
Decision Date:	04/04/2014	UR Denial Date:	11/26/2013
Priority:	Standard	Application Received:	12/09/2013

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 and rehabilitation, has a subspecialty in Pain Medicine, 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:

The patient is a 54-year-old who was injured on 05/26/2011. Injury was not provided. Prior treatment history has included extracorporeal shockwave, medication, physical and manipulative therapy; and injections. Diagnostic studies reviewed include MRI of the right wrist performed 06/01/2012 revealed subchondral cysts, of the central portion of the capitate bone measuring 3 mm in size; increased signal beneath the transverse retinaculum near the median nerve which may represent carpal tunnel syndrome; and no other abnormalities noted. Multiplanar, Multiecho MRI of the right shoulder performed 08/01/2012 revealed focal, articular side, partial tear of posterior fibers of supraspinatus muscles at insertion site; small subacromial/subdeltoid bursal effusion; fluid ins subscapularis recess; acromioclavicular joint hypertrophy; no other obvious abnormality noted. Operative note dated 12/17/2012 documented the patient to have received a cervical epidural steroid injection. X-ray of the chest performed 03/11/2013 revealed no active cardiopulmonary disease; discogenic spondylosis, thoracic spine was noted. The patient had normal electromyogram study of the cervical spine and upper extremities. Clinic note dated 10/04/2013 documented the patient to have complaints of left and right shoulder pain; burning pain, right shoulder; stiff and swollen hands; numb fingers; right wrist painful; intense pain in the back of the neck, radiating to right side of the neck ; symptoms of headache, front and back. Clinic note dated 10/24/2013 documented the patient to have complaints of cervical spine, thoracic spine, and lumbar spine, and lumbar spine pain, myospasm, weakness with loss of range of motion. The patient also complained of right wrist pain, numbness, and weakness. Objective findings on exam included the patient has limited range of motion of the lumbar spine and right shoulder as well as painful range of motion of the cervical spine and right wrist/hand. The patient has pain on palpation, taut muscles/spasm of the cervical spine, thoracic spine, lumbar spine, and right wrist/hand as well as sensory loss in the right upper extremity and lower

extremities. Trigger points are in the cervical spine, thoracic spine, lumbar spine, and right wrist/hand. The patient has positive orthopedic tests of the cervical spine, lumbar spine, and right wrist/hand. The patient denies dry mouth and left shoulder pain. The patient has improvement with functional assessment. The patient has serious chronic condition. The patient has slower progression than expected with 80% improvement. Clinic note dated 10/25/2013 documented radiating pain in neck and shoulders, more on the right; numbness in both hands and fingers; right arm goes numb; Burning pain right shoulder-side of upper arm and neck at times

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy, twice per week for four weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The Physician Reviewer's decision rationale: According to the referenced guidelines, patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. The medical records do not document the patient's response to prior physical therapy sessions. Detailed assessment regarding the patient's response to previously rendered care, as well as clear evidence that the patient currently presents with a significant flare or exacerbation of her chronic pain condition as to warrant return to care, is required. The request for physical therapy, twice per week for four weeks, is not medically necessary.