

Case Number:	CM14-0033160		
Date Assigned:	06/20/2014	Date of Injury:	02/11/2010
Decision Date:	07/23/2014	UR Denial Date:	02/24/2014
Priority:	Standard	Application Received:	03/17/2014

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 patient is a 50 year old female who was injured on 02/11/2010 while she was escorting a handcuffed suspect. The patient underwent left shoulder repair on 07/07/2010. Diagnostic studies reviewed include MRI of the cervical spine dated 05/10/2013 revealed Abnormal asymmetric T2 hyperintensity of the left brachial plexus including the C5-C7 roots and more distal segments. Findings are suggestive of brachial plexopathy, possibly inflammatory however a traction injury may have similar imaging findings. Progress report dated 07/23/2013 documented the patient presented with complaints of an inability to make a complete fist with her left hand with associated numbness and tingling affecting her left thumb, long fingers and index fingers. On exam, positive Durkan compression test, positive Phalen's test. Sensation is intact. Assessment and plan include left upper extremity complex regional pain syndrome as well as probable left carpal tunnel syndrome and left hand intrinsic tightness. On note progress report dated 02/13/2014 is illegible. The patient has a diagnosis of reflex sympathetic dystrophy and radiculitis. Prior utilization review dated 02/24/2014 states the request for Physical therapy 1 x4, then once monthly x6 months for left upper extremity (LUE) is not authorized as medical necessity has not been established and there is no documented functional improvement. Patient had more than 100 PT since 2010.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 1 x4, then once monthly x6 months for left upper extremity (LUE):
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (updated 12/16/13); Official Disability Guidelines (ODG) Physical Therapy Guidelines.

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

Decision rationale: As per CA MTUS Chronic pain medical treatment guidelines, physical medicine 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. Additionally, patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. According to the medical record, this patient had more than 100 PT since 2010. She should be well versed in home exercise at this point. The medical necessity for this request is not established. Therefore, the request is not medically necessary.