

Case Number:	CM14-0088086		
Date Assigned:	07/23/2014	Date of Injury:	02/28/2013
Decision Date:	09/18/2014	UR Denial Date:	05/29/2014
Priority:	Standard	Application Received:	06/11/2014

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 Illinois. 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 47-year-old female who reported an injury on 02/28/2013. The mechanism of injury was not provided for clinical review. The diagnoses included carpal tunnel syndrome, right rotator cuff syndrome, myofascitis, anxiety, headaches, insomnia, and right shoulder pain. The previous treatments included TENS unit, medication, physical therapy, and cold packs. Diagnostic testing included an EMG/NCV and an MRI. Within the clinical note dated 01/09/2014, it was reported that the injured worker complained of right shoulder pain, myospasms, and weakness with loss of range of motion. She complained of migraine headaches bilaterally. Upon the physical examination, the provider noted the injured worker painful range of motion of the right shoulder. He noted pain on palpation, taut muscles/spasms of the right shoulder, edema/swelling in the right shoulder, and sensory loss in the right upper extremity. The provider indicated trigger points were in the right shoulder. The injured worker had a positive orthopedic chest of the right shoulder. The provider requested for physical therapy 2 times a week for 6 weeks. However, a rationale was not provided for clinical review. The Request for Authorization was not provided for clinical review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy 2 x week x 6 weeks Cervical/Right Shoulder: Upheld

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

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

Decision rationale: The request for Physical Therapy 2 x week x 6 weeks Cervical/Right Shoulder is not medically necessary. The California MTUS Guidelines state that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, and range of motion. The Guidelines allow for a fading of treatment frequency plus active self-directed home physical medicine. The Guidelines note for neuralgia and myalgia 8 to 10 visits of physical therapy are recommended. There is a lack of documentation indicating the injured worker's prior course of physical therapy as well as the efficacy. The number of sessions the injured worker has previously undergone was not provided for clinical review. The request for an additional 12 sessions of physical therapy exceeds the Guideline recommendations of 8 to 10 visits. Therefore, the request for Physical Therapy 2 x week x 6 weeks Cervical/Right Shoulder is not medically necessary.