

Case Number:	CM14-0091707		
Date Assigned:	07/25/2014	Date of Injury:	02/07/2004
Decision Date:	09/23/2014	UR Denial Date:	05/19/2014
Priority:	Standard	Application Received:	06/17/2014

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:

This is a patient with a date of injury of February 7, 2014. A utilization review determination dated May 19, 2014 recommends modified certification for physical therapy of the left shoulder and wrist. Certification was requested for 8 visits and modified to 4 visits. the reviewer noted that there was a contracture. A progress note dated April 3, 2014 identifies subjective complaints of right shoulder pain, right elbow pain, and sleep deprivation due to pain. Physical examination findings identify decreased cervical range of motion, positive tenderness to palpation in the subacromial space, by said that though groove, and soft tissues of both shoulders. Additionally, there is weakness noted in the right upper extremity with tenderness to palpation around the right and left wrists. Diagnoses include status post right carpal tunnel release, postoperative cervical spine 1 level fusion, right shoulder internal derangement, right lateral epicondylitis, right ganglion cyst, and secondary sleep deprivation. The treatment plan recommends physical therapy for the left shoulder and left wrist 2 times a week for 4 weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy 2 times per week for 4 weeks- left Shoulder/ Wrist: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines-Shoulder, Forearm, Wrist and Hand.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 200, 265. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Physical Therapy, Forearm, Wrist, and Hand Chapter, Physical Therapy.

Decision rationale: Regarding the request for physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, there is no indication that the patient has undergone prior physical therapy. Additionally, there are objective deficits which remain to be addressed with the currently requested therapy. Although a 6 visit trial may be more appropriate; since the current request is for multiple diagnoses and body parts, and 8 visit trial of physical therapy seems reasonable. Ongoing use of physical therapy would need to be accompanied by documentation of objective functional improvement, ongoing objective treatment goals, and a statement indicating why any remaining deficits would be unable to be addressed with an independent program of home exercise. Therefore, the currently requested physical therapy 2 times a week for 4 weeks for the left shoulder and wrist is medically necessary.