

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM15-0018543 | | |
| Date Assigned: | 02/06/2015 | Date of Injury: | 08/25/2006 |
| Decision Date: | 04/03/2015 | UR Denial Date: | 12/30/2014 |
| Priority: | Standard | Application Received: | 01/31/2015 |

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: California, Arizona
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 51-year-old female who reported an injury on 08/25/2006. The mechanism of injury was not stated. The current diagnoses include lateral epicondylitis, adhesive capsulitis, and sprain of an unspecified site of the shoulder and upper arm. The injured worker presented on 12/12/2014 for a followup evaluation with complaints of left shoulder popping. The injured worker also reported an increase in symptoms with the cold weather. There has been no change in the functional capability. The injured worker was pending authorization for an H wave unit. Upon examination, there was 170 degrees left shoulder flexion and abduction with crepitus on passive range of motion, mild left subacromial tenderness, and weakness with a positive biceps roll test. Recommendations at that time included 6 sessions of physical therapy. The injured worker was also issued prescriptions for Lexapro 5 mg, Flexeril 5 mg, and Voltaren gel 1%. A Request for Authorization form was then submitted on 12/15/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy for the left shoulder 2 times a week for 3 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine.

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

Decision rationale: The California MTUS Guidelines state active therapy 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. In this case, there was no documentation of the previous course of physical therapy with evidence of objective functional improvement. Given the above, the request for additional treatment would not be supported. As such, the request is not medically appropriate in this case.