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| Case Number: | CM15-0166521 | | |
| Date Assigned: | 09/04/2015 | Date of Injury: | 02/25/2013 |
| Decision Date: | 10/13/2015 | UR Denial Date: | 08/12/2015 |
| Priority: | Standard | Application Received: | 08/25/2015 |

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: Pennsylvania, Ohio, California
 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 42 year old female, who sustained an industrial-work injury on 2-25-13. She reported initial complaints of shoulder, left wrist, left hand, and left knee pain. The injured worker was diagnosed as having left shoulder partial rotator cuff tear, bilateral wrist sprain-strain verses carpal tunnel syndrome, bilateral elbow strain, compensatory chronic left trapezial strain, left knee patellofemoral pain, and cervical spine sprain-strain. Treatment to date has included medication. Currently, the injured worker complains of persistent bilateral shoulder, left wrist, left hand, and left knee pain rated 8 out of 10. Over the counter medication brings it down to 6 out of 10. Per the primary physician's progress report (PR-2) on 7-29-15, exam noted ambulation was normal. The left shoulder revealed tenderness with palpation, reduced range of motion, and strength of 4 out of 5. The left wrist had tenderness with palpation over the radial border, full active range of motion in all planes, and positive Finkelstein's test. The left knee had tenderness to palpation, full flexion and extension, and strength of 4 out of 5. Current plan of care includes physical therapy and medication. The requested treatment included Physical therapy 2 times a week for 6 weeks for the left shoulder, Robaxin 750mg, and Tylenol 3.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 2 times a week for 6 weeks for the left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

Decision rationale: MTUS encourages physical therapy with an emphasis on active forms of treatment and patient education. This guideline recommends transition from supervised therapy to active independent home rehabilitation. Given the timeline of this injury and past treatment, the patient would be anticipated to have previously transitioned to such an independent home rehabilitation program. The records do not provide a rationale at this time for additional supervised rather than independent rehabilitation. This request is not medically necessary.

Robaxin 750mg, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

Decision rationale: MTUS recommends the use of non-sedating muscle relaxants for short-term use only. This guideline recommends Robaxin only for a short course of therapy. The records in this case do not provide an alternate rationale to support longer or ongoing use. This request is not medically necessary.

Tylenol 3, #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

Decision rationale: MTUS discusses in detail the 4 A's of opioid management, emphasizing the importance of dose titration vs. functional improvement and documentation of objective, verifiable functional benefit to support an indication for ongoing opioid use. The records in this case do not meet these 4 A's of opioid management and do not provide a rationale or diagnosis overall for which ongoing opioid use is supported. Therefore this request is not medically necessary.