

Case Number:	CM15-0188725		
Date Assigned:	09/30/2015	Date of Injury:	08/15/2010
Decision Date:	11/12/2015	UR Denial Date:	08/19/2015
Priority:	Standard	Application Received:	09/25/2015

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: 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 44 year old female, who sustained an industrial injury on 8-15-10. The injured worker is being treated for status post posterior fusion L4-5, left shoulder SLAP tear with impingement, right shoulder partial rotator cuff tear and narrowing of neural foramina bilaterally C5-6 and extruded disc C6-7, chronic pain syndrome, probable depression, bilateral ulnar neuropathy of elbows and possible reflex sympathetic dystrophy or chronic regional pain syndrome of right upper extremity. Treatment to date has included oral medications including Percocet, Trazodone, Clonazepam, Soma and Xanax; spinal fusion (6-17-14), facet injections, lumbar fusion and activity modifications. On 7-22-15, the injured worker complains of constant neck pain, frequent headaches, bilateral radiating arm pain and numbness, bilateral shoulder pain and bilateral hand pain with popping in bilateral shoulders and elbows and swelling of hands and wrists and numbness over left lateral elbow. Disability status is noted to be permanent and stationary. Physical exam performed on 7-22-15 revealed restricted cervical range of motion, normal gait, well healed midline lumbosacral scar and is slow to rise from seated position; pain is noted with range of motion of bilateral elbow and wrists. A request for authorization was submitted on 8-11-15 for physical therapy 2 times a week for 6 weeks. There is no documentation to indicate if the injured worker has received previous physical therapy. On 8-19-15 a request for 12 physical therapy visits for right elbow was non-certified by utilization review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Twelve (12) physical therapy, 2x6 weeks for the right elbow as an outpatient: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines, Elbow (Acute & Chronic).

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

Decision rationale: The patient presents with neck pain radiating to bilateral arms, bilateral shoulder pain, and bilateral hand pain. The request is for twelve (12) physical therapy, 2x6 weeks for the right elbow as an outpatient. Examination to the bilateral elbows on 07/22/15 revealed a full range of motion with some pain. Per 08/11/15 Request For Authorization form, patient's diagnosis include status post posterior fusion L4-L5 and L5-S1; left shoulder slap tear with impingement; right shoulder partial rotator cuff tear; MRI report stating there is narrowing of the neural foramina bilaterally, left greater than right C5-C6, and an extruded disc C6-C7; chronic pain syndrome; probable depression; bilateral ulnar neuropathy at the elbows; possible reflex sympathetic dystrophy or chronic regional pain syndrome, right upper extremity. Patient is permanent and stationary. The MTUS Chronic Pain Management Guidelines 2009, pages 98 and 99, Physical Medicine section, has the following: "Recommended as indicated below. Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." MTUS guidelines pages 98, 99 states that for "Myalgia and myositis, 9-10 visits are recommended over 8 weeks. For Neuralgia, neuritis, and radiculitis, 8-10 visits are recommended." In Request For Authorization form dated 08/11/15, the treater is requesting authorization to have the patient undergo physical therapy twice a week for 6 weeks to address her symptoms. Review of the medical records provided did not indicate prior physical therapy. The patient continues with pain in the upper extremities and is diagnosed with bilateral ulnar neuropathy at the elbows. Given the patient's condition, a short course of physical therapy would be indicated. However, the request for 12 sessions exceeds what is allowed by the guidelines and therefore, the request is not medically necessary.