

Case Number:	CM15-0207832		
Date Assigned:	10/26/2015	Date of Injury:	03/12/2014
Decision Date:	12/07/2015	UR Denial Date:	10/21/2015
Priority:	Standard	Application Received:	10/22/2015

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:

This is a 42 year old female with a date of injury on 3-12-14. A review of the medical records indicates that the injured worker is undergoing treatment for a right shoulder injury. Progress report dated 10-5-10 reports continued complaints of right shoulder pain with paresthesias and numbness in the right hand fingers one through 5. The pain increases with activity is bothered by laying on her right side. She reports physical therapy was helping and the pain came back as soon as she stopped. Physical exam: tenderness to palpation over the ac joint and the bicipital groove region, passive range of motion right shoulder is 100 of forward flexion, 90 of abduction, and 40 of external rotation, passive range of motion is full in all planes. Corticosteroid injection given at this visit and tolerated well. EMG nerve conduction study of bilaterally upper extremities showed mild compression of the median nerve at the wrists equally. Treatments include: medication, physical therapy, brace and injections. Request for authorization was made for Physical therapy, right shoulder, Qty 12 and Physical therapy, right wrist/hand, Qty 12. Utilization review dated 10-21-15 modified the request to certify Physical therapy, right shoulder, Qty 6 and Physical therapy, right wrist/hand, Qty 2.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy, right shoulder, Qty 12: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Shoulder - Adhesive capsulitis.

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

Decision rationale: Review indicates the request for PT to the right shoulder was modified for 6. The Chronic Pain Guidelines allow for 9-10 visits of physical therapy with fading of treatment to an independent self-directed home program for flare-up, new injury, progressive deterioration, or with documented functional improvement in terms of increased ADLs with decreased pharmacological profile and medical utilization. For chronic injury with new findings, therapy may be medically appropriate to allow for relief and re-instruction on a home exercise program for a chronic injury. It appears the patient made some progress with therapy; however, request for continued therapy is beyond the quantity for guidelines criteria for reassessment with further consideration for additional sessions upon documented functional benefit. Submitted reports have not adequately demonstrated the indication to support for excessive quantity of an additional 12 PT sessions without extenuating circumstances established beyond the guidelines. The patient should have been previously instructed on an independent home exercise program. The Physical therapy, right shoulder, Qty 12 is not medically necessary and appropriate.

Physical therapy, right wrist/hand, Qty 12: 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: Review indicates the request for PT to the right wrist/hand was modified for 2 sessions. The Chronic Pain Guidelines allow for 9-10 visits of physical therapy with fading of treatment to an independent self-directed home program for flare-up, new injury, progressive deterioration, or with documented functional improvement in terms of increased ADLs with decreased pharmacological profile and medical utilization. For chronic injury with new findings, therapy may be medically appropriate to allow for relief and re-instruction on a home exercise program for a chronic injury. It appears the patient made some progress with therapy; however, request for continued therapy is beyond the quantity for guidelines criteria for reassessment with further consideration for additional sessions upon documented functional benefit. Submitted reports have not adequately demonstrated the indication to support for excessive quantity of an additional 12 PT sessions without extenuating circumstances established beyond the guidelines. The patient should have been previously instructed on an independent home exercise program. The Physical therapy, right wrist/hand, Qty 12 is not medically necessary and appropriate.

