

Case Number:	CM15-0057760		
Date Assigned:	04/02/2015	Date of Injury:	12/04/2013
Decision Date:	05/04/2015	UR Denial Date:	02/23/2015
Priority:	Standard	Application Received:	03/26/2015

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 54-year-old female, who sustained an industrial injury on December 4, 2013. She has reported neck pain, left shoulder pain, left elbow pain, and left wrist and hand pain. Diagnoses have included cervical spine strain/sprain, left shoulder strain/sprain and rotator cuff tear, left elbow strain/sprain, left elbow medial and lateral epicondylitis, and left carpal tunnel syndrome. Treatment to date has included medications, physical therapy, acupuncture, and shock wave therapy. A progress note dated January 20, 2015 indicates a chief complaint of radicular neck pain and muscle spasms with numbness and tingling of the left arm, left shoulder pain radiating to the arm and fingers, left elbow pain and muscle spasms with weakness, numbness, tingling and pain radiating to the hand and fingers, and left wrist pain and muscle spasms with weakness, numbness, tingling and pain radiating to the hand and fingers. The treating physician documented a plan of care that included medications, continuation of physical therapy, continuation of acupuncture, and continuation of shock wave therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therpay 3 x per week x 6 weeks cervical spine, left shoulder, left wrist: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy, pages 98-99.

Decision rationale: Physical therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. However, there is no clear measurable evidence of progress with the PT treatment already rendered including milestones of increased ROM, strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints, clinical findings, and functional status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. The Chronic Pain Guidelines allow for 9-10 visits of physical therapy with fading of treatment to an independent self-directed home program. It appears the employee has received significant therapy sessions without demonstrated evidence of functional improvement to allow for additional therapy treatments. There is no report of acute flare-up, new injuries, or change in symptom or clinical findings to support for formal PT in a patient that has been instructed on a home exercise program for this chronic injury. Submitted reports have not adequately demonstrated the indication to support further physical therapy when prior treatment rendered has not resulted in any functional benefit with request in quantities beyond guidelines' recommendations. The Physical Therapy 3 x per week x 6 weeks cervical spine, left shoulder, left wrist is not medically necessary and appropriate.