

Case Number:	CM13-0065836		
Date Assigned:	01/03/2014	Date of Injury:	02/19/2011
Decision Date:	05/19/2014	UR Denial Date:	11/13/2013
Priority:	Standard	Application Received:	12/13/2013

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. The expert reviewer is Board Certified in Family Medicine and is licensed to practice in Arizona. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

Patient is a 22 year old female with a date of injury on 2/19/2011. Diagnoses include lumbar sprain, abrasion to hip and leg, and shoulder impingement, carpal tunnel syndrome, and knee derangement. Subjective complaints are of left knee pain described as burning, stabbing, and moderately severe. There is also right shoulder pain which is worse with overhead movement, and right wrist pain with weakness. Physical exam shows tenderness over right anterior Final Determination Letter for IMR Case Number CM13-0065836 3 shoulder, intact strength, and full range of motion. Patient had a positive Neer, Hawkin's, cross-chest test, and AC joint compression test. Previous treatments have included knee brace and chiropractic care. Medications include Ultracet, Prilosec, Anaprox, and cyclobenzaprine. Right shoulder x-ray did not show any abnormalities. Submitted documentation does not identify any previous course of physical therapy. The request for physical therapy right upper extremity three times a week for four weeks is not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY RIGHT UPPER EXTREMITY THREE TIMES A WEEK FOR FOUR WEEKS: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Physical Therapy.

Decision rationale: The ODG recommendations for rotator cuff impingement syndrome are for 10 visits over 8 weeks for medical treatment. The request is for 12 treatments over 4 weeks. Therefore, this request exceeds guideline recommendations and the medical necessity has not been established.

PHYSICAL THERAPY RIGHT UPPER EXTREMITY: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Physical Therapy

Decision rationale: The ODG recommendations for rotator cuff impingement syndrome are for 10 visits over 8 weeks for medical treatment. The request as written above does not state the amount or duration of proposed treatment. Therefore, this request for an unspecified amount of physical therapy is not consistent with guideline recommendations and the medical necessity has not been established.