

Case Number:	CM14-0094064		
Date Assigned:	09/12/2014	Date of Injury:	09/03/2013
Decision Date:	10/15/2014	UR Denial Date:	06/06/2014
Priority:	Standard	Application Received:	06/20/2014

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 Physical Medicine and Rehabilitation, and is licensed to practice in California. 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:

The injured worker is a 49-year-old female who reported an injury on 09/03/2013 due to an unknown mechanism. Diagnoses were: cervical spine sprain and strain; clinical cervical radiculopathy; tendonitis/impingement syndrome, right shoulder; rule out rotator cuff tear; status post apparent open reduction and internal fixation, right olecranon process and coronoid process fractures, with palpable loose bodies; lumbar spine sprain/strain; left knee sprain/strain with degenerative changes, chondromalacia, synovitis, and possible internal derangement; and status post previous lumbar spine surgery. Past treatments were left knee cortisone injection and physical therapy. Physical examination on 07/08/2014 revealed that the injured worker was attending a course of physical therapy with only temporary benefit reported. The injured worker had complaints of continued pain and stiffness in the neck and upper back, pain and stiffness in the right shoulder, left elbow, low back and ongoing pain to the left knee. Examination of the cervical spine revealed tenderness to palpation over the para-axial musculature, with spasm present. Range of motion for the cervical spine was limited. Examination of the right shoulder revealed tenderness to palpation over the tip of the acromion and supraspinatus tendon. Impingement testing was positive and drop arm testing was equivocal on the right. Range of motion was limited for the right shoulder. Examination of the right elbow revealed tenderness to palpation over the olecranon process, the coronoid, and the medial and lateral epicondyles. There were palpable loose bodies noted. Range of motion for the right elbow was limited. Strength was 4/5 on the right and 5/5 on the left. Sensory response over the C5, C6 and C7 nerve roots was decreased on both the right and the left sides. Deep tendon reflexes were normal. Examination of the lumbar spine revealed tenderness to palpation over the para-axial musculature, with spasticity. Range of motion for the lumbar spine was limited. Straight leg raising was positive, bilaterally at 60 degrees. Medications were not reported. Treatment plan

was for additional physical therapy 2 times 6. The rationale and Request for Authorization were not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

ADDITIONAL PHYSICAL THERAPY 2X6: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: The injured worker is a 49-year-old female who reported an injury on 09/03/2013 due to an unknown mechanism. Diagnoses were: cervical spine sprain and strain; clinical cervical radiculopathy; tendonitis/impingement syndrome, right shoulder; rule out rotator cuff tear; status post apparent open reduction and internal fixation, right olecranon process and coronoid process fractures, with palpable loose bodies; lumbar spine sprain/strain; left knee sprain/strain with degenerative changes, chondromalacia, synovitis, and possible internal derangement; and status post previous lumbar spine surgery. Past treatments were left knee cortisone injection and physical therapy. Physical examination on 07/08/2014 revealed that the injured worker was attending a course of physical therapy with only temporary benefit reported. The injured worker had complaints of continued pain and stiffness in the neck and upper back, pain and stiffness in the right shoulder, left elbow, low back and ongoing pain to the left knee. Examination of the cervical spine revealed tenderness to palpation over the para-axial musculature, with spasm present. Range of motion for the cervical spine was limited. Examination of the right shoulder revealed tenderness to palpation over the tip of the acromion and supraspinatus tendon. Impingement testing was positive and drop arm testing was equivocal on the right. Range of motion was limited for the right shoulder. Examination of the right elbow revealed tenderness to palpation over the olecranon process, the coronoid, and the medial and lateral epicondyles. There were palpable loose bodies noted. Range of motion for the right elbow was limited. Strength was 4/5 on the right and 5/5 on the left. Sensory response over the C5, C6 and C7 nerve roots was decreased on both the right and the left sides. Deep tendon reflexes were normal. Examination of the lumbar spine revealed tenderness to palpation over the para-axial musculature, with spasticity. Range of motion for the lumbar spine was limited. Straight leg raising was positive, bilaterally at 60 degrees. Medications were not reported. Treatment plan was for additional physical therapy 2 times 6. The rationale and Request for Authorization were not submitted.