

Case Number:	CM15-0125057		
Date Assigned:	07/09/2015	Date of Injury:	08/11/2010
Decision Date:	08/12/2015	UR Denial Date:	06/26/2015
Priority:	Standard	Application Received:	06/29/2015

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: Pennsylvania, Ohio, 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 63 year old female with an industrial injury dated 08/11/2010. The injured worker's diagnoses include right shoulder adhesive capsulitis, right shoulder rotator cuff syndrome, right elbow lateral epicondylitis and right wrist sprain/strain. Treatment consisted of Magnetic Resonance Imaging (MRI), Electromyography (EMG)/Nerve conduction velocity (NCV), prescribed medications, 20 sessions of physical therapy, acupuncture treatment, chiropractic treatment, cortisone injections, epidural injection and periodic follow up visits. In a progress note dated 05/18/2015, the injured worker reported constant neck and forearms pain, intermittent right wrist pain, intermittent right sided low back pain, intermittent right shoulder and intermittent right hand pain. Objective findings revealed light tenderness over the acromioclavicular joint (AC), coracoid process, BT (bicep tendon) groove, deltoid bursae and glenohumeral joint. Restricted range of motion in the right shoulders and right wrists were also noted on exam. The treating physician prescribed services for physical therapy to the right shoulder, elbow and wrist with duration and frequency not given.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy to the right shoulder, elbow and wrist duration and frequency not given:
 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: MTUS encourages physical therapy with an emphasis on active forms of treatment and patient education. This guideline recommends transition from supervised therapy to active independent home rehabilitation. Given the timeline of this injury and past treatment, the patient would be anticipated to have previously transitioned to such an independent home rehabilitation program. The records do not provide a rationale at this time for additional supervised rather than independent rehabilitation. Moreover the request is not specific regarding the duration and frequency of proposed therapy and thus the request cannot be interpreted for this additional reason. For these multiple reasons, this request is not medically necessary.