

Case Number:	CM15-0127688		
Date Assigned:	07/14/2015	Date of Injury:	08/03/2012
Decision Date:	08/10/2015	UR Denial Date:	06/04/2015
Priority:	Standard	Application Received:	07/01/2015

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: Emergency Medicine

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 63 year old female with an August 3, 2012 date of injury. A progress note dated May 26, 2015 documents subjective complaints (coverage is for the neck, right arm including shoulder, elbow, wrist and hand, as well as the low back; still has a bout of asthma; spasms along the neck), objective findings (tenderness along the medial epicondyle is significant; tenderness on the rotator cuff noted; limited motion along the wrist and thumb; positive facet loading), and current diagnoses (discogenic cervical condition with disc disease from C3 to C7 associated with headaches; impingement syndrome of the right shoulder; medial and lateral epicondylitis on the right; wrist joint inflammation; stenosing tenosynovitis along the first extensor compartment of the wrist on the right; discogenic lumbar condition with radicular component down the right lower extremity; element of sleep, depression, gastroesophageal reflux disease and weight gain). Treatments to date have included right first extensor release, therapy, lumbar facet injection with relief, magnetic resonance imaging of the neck that showed disc disease from C3 to C7, magnetic resonance imaging of the right shoulder that showed tendinosis and acromioclavicular joint wear, magnetic resonance imaging of the right wrist that showed scapholunate ligament tear, magnetic resonance imaging of the lumbar spine that showed three level disc disease, chiropractic treatments, wrist bracing, back bracing, transcutaneous electrical nerve stimulator unit, and activity modifications. The treating physician documented a plan of care that included physical therapy for the cervical spine, low back, right shoulder and wrist.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy x 12 for the cervical, low back, right shoulder and wrist: 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 requested physical therapy x 12 for the cervical, low back, right shoulder and wrist is not medically necessary. CA MTUS 2009, Chronic Pain Medical Treatment Guidelines, Physical Medicine, Page 98-99, recommend continued physical therapy with documented objective evidence of derived functional improvement. The injured worker has subjective complaints (coverage is for the neck, right arm including shoulder, elbow, wrist and hand, as well as the low back; still has a bout of asthma; spasms along the neck), objective findings (tenderness along the medial epicondyle is significant; tenderness on the rotator cuff noted; limited motion along the wrist and thumb; positive facet loading. The treating physician has not documented objective evidence of derived functional improvement from completed physical therapy sessions, nor the medical necessity for additional physical therapy to accomplish a transition to a dynamic home exercise program. The criteria noted above not having been met, physical therapy x 12 for the cervical, low back, right shoulder and wrist is not medically necessary.