

Case Number:	CM15-0070515		
Date Assigned:	04/20/2015	Date of Injury:	04/19/2013
Decision Date:	05/21/2015	UR Denial Date:	04/09/2015
Priority:	Standard	Application Received:	04/14/2015

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, Hawaii
 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 53 year old female who sustained an industrial injury on April 19, 2013. Prior treatment includes medications, MRI of the left shoulder, right shoulder surgery and medications. Currently the injured worker complains of neck pain with radiation of pain to the left upper extremity, left shoulder pain, left wrist pain and low back pain. Diagnoses associated with the request include rotator cuff tear of the left shoulder, possible left sacroiliac joint dysfunction, left cubital tunnel syndrome, left carpal tunnel syndrome, status post right shoulder surgery and ganglion cyst of the left wrist. The treatment plan includes physical therapy of the cervical, spine, lumbar spine and the left wrist, and medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

12 Physical Therapy, 3 times a week for 4 weeks for the left wrist as an outpatient: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The patient presents with pain affecting the left shoulder, left wrist, low back, and neck with radiation to the left upper extremity. The current request is for 12 Physical Therapy, 3 times a week for 4 weeks for the left wrist as an outpatient. The treating physician report dated 3/13/15 (27B) states: Request authorization for a reconsideration of physical therapy, 3x4 to the cervical spine, lumbar spine and left wrist. The report goes on to state: the patient has not had physical therapy to the neck, back and left wrist and recommended that she undergo physical therapy to these areas. The MTUS guidelines only provide a total of 8-10 sessions and the patient is expected to then continue on with a home exercise program. The medical reports provided do not show that the patient has undergone surgery for the left wrist nor has she received any prior physical therapy. In this case, the current request of 12 visits exceeds the recommendation of 8-10 visits as outlined by the MTUS guidelines on page 99. Furthermore, there was no rationale by the physician in the documents provided as to why the patient requires treatment above and beyond the MTUS guidelines. Recommendation is for denial and is medically necessary.