

Case Number:	CM13-0049559		
Date Assigned:	12/27/2013	Date of Injury:	02/01/2011
Decision Date:	03/12/2014	UR Denial Date:	10/11/2013
Priority:	Standard	Application Received:	11/08/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Family Practice 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 physician 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 patient is a 28-year-old female who reported an injury on 11/01/2009. The patient is diagnosed as status post carpal tunnel release on 09/11/2011, effusion and subchondral cyst in the right wrist, insomnia and rule out medial epicondylitis. The patient was seen by [REDACTED] on 09/25/2013. The patient reported ongoing pain in the right wrist and right elbow. It was noted that the patient has received 40 sessions of physical therapy to date. The physical examination revealed palpable tenderness over the medial epicondyle on the right, full range of motion and positive Tinel's testing in the elbow. The patient also demonstrated palpable tenderness over the wrist in the thenar area with full range of motion and positive Tinel's and Phalen's testing. The treatment recommendations included extracorporeal shockwave therapy to the right wrist and forearm as well as the continuation of a paraffin bath unit. A previous request by [REDACTED] on 08/27/2013 included physical therapy to the right wrist and forearm twice per week for 4 weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy with modalities two times a week for four weeks for the right wrist and right forearm: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Section Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist & Hand Chapter, Physical Therapy.

Decision rationale: The California MTUS Guidelines state that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function and range of motion and can alleviate discomfort. Guidelines allow for a fading of treatment frequency plus active, self-directed home physical medicine. As per the documentation submitted, the patient has completed at least 40 sessions of physical therapy to date. However, documentation of the previous course of treatment with total treatment duration and efficacy was not provided for review. Additionally, the patient's physical examination revealed full range of motion of the wrist and elbow. Based on the clinical information received, the request is non-certified.

Low energy extracorporeal shockwave treatments 3 times (3 per diagnosis - 1 treatment every 2 weeks) for the right wrist and right forearm: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265-266. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Extracorporeal shock wave therapy (ESWT).

Decision rationale: The California MTUS/ACOEM Practice Guidelines state physical modalities have no proven efficacy in treating acute hand, wrist or forearm symptoms. The Official Disability Guidelines state that extracorporeal shockwave therapy is recommended for patients with calcifying tendonitis of the shoulder despite 6 months of standard treatment. As per the documentation submitted, there was no evidence of a recent failure to respond to more traditional conservative treatment, including activity modification, medications and physical therapy. Based on the clinical information received, the request is non-certified.