

Case Number:	CM13-0070580		
Date Assigned:	01/08/2014	Date of Injury:	05/24/2011
Decision Date:	09/11/2014	UR Denial Date:	11/26/2013
Priority:	Standard	Application Received:	12/26/2013

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 Illinois. 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 55-year-old male who reported an injury on 06/24/2011. The mechanism of injury was not specifically stated. The current diagnoses include right wrist ligamentous injury, right superficial radial sensory neuropathy, sleep disorder, right moderate carpal tunnel syndrome, anxiety reaction, right knee internal derangement, left ankle sprain, right hemiparesis, aphasia, cervical spine strain, lumbar radiculopathy, right wrist internal derangement, and left shoulder impingement syndrome. The injured worker was evaluated on 11/12/2013. It is noted that previous conservative treatment includes physical therapy, medication management, and individual psychotherapy. Physical examination revealed tenderness to palpation of the cervical spine, spasm, restricted range of motion of the cervical spine, hyperactive right upper and lower extremity reflexes, reduced sensation in the right hand and right foot, decreased left shoulder range of motion, positive impingement testing, tenderness to palpation of the right wrist joint line, reduced grip strength on the right, tenderness to palpation of the lumbar spine, spasm, restricted lumbar range of motion, and normal range of motion of the right knee. Treatment recommendations at that time included a refill of omeprazole, authorization for a psychiatrist evaluation, and physical therapy 3 times per week for 4 weeks for the right knee and right wrist. There was no DWC Form RFA submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional Physical Therapy Three Times a Week for Four Weeks for the Right 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 California MTUS Guidelines state active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. As per the documentation submitted, the injured worker has previously participated in physical therapy. However, there was no documentation of the previous course of treatment with evidence of objective functional improvement. There is also no documentation of a significant functional limitation. The medical necessity for ongoing treatment has not been established. As such, the request for additional physical therapy three times a week for four weeks for the right wrist is not medically necessary.