

Case Number:	CM14-0176072		
Date Assigned:	10/29/2014	Date of Injury:	01/10/2011
Decision Date:	12/16/2014	UR Denial Date:	09/26/2014
Priority:	Standard	Application Received:	10/23/2014

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 Emergency Medicine and is licensed to practice in Texas. 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 61-year-old male who reported an injury on 01/10/2011 due to overhead reaching. Diagnoses included status post left wrist carpal tunnel release; herniated lumbar disc with retrolisthesis at the level of L5-S1 with radiculopathy right greater than left; internal derangement of the right knee; abrasion anteromedial aspect of the right knee; strain, left thumb; right shoulder tendonitis, impingement; left shoulder tendonitis, impingement; herniated thoracic disc; contusion of the chest wall with residual costochondritis; internal derangement of left wrist; triangular fibrocartilage tear; left hand tendonitis; carpal tunnel syndrome; symptoms of anxiety and depression; symptoms of insomnia. Surgical history included left wrist carpal tunnel release on 05/18/2013, left shoulder arthroscopy on 01/05/2012. Diagnostic testing included MRI of left shoulder on 10/18/2011, MRI of right shoulder 06/27/2011, MRI of left hand 07/05/2011, MRI of left wrist 07/05/2011, MRI of lumbar spine 06/27/2011, MRI of right knee 07/05/2011, an anatomical impairment testing on 06/27/2011 and 07/05/2011. The patient complains of pain to right shoulder aggravated with overhead reaching and overhead work. The patient complains of pain to right wrist that is aggravated with repetitive forceful gripping and grasping on 08/22/2014. The physical examination revealed right shoulder range of motion was a flexion of 160 degrees, extension 35 degrees, abduction 150 degrees, adduction 35 degrees, internal rotation 65 degrees, external 70 degrees. The impingement test was positive on the right. There was tenderness over the greater tuberosity of the right humerus. There was subacromial grinding and clicking of the right humerus. There was tenderness over the rotator cuff muscles on the right. The physical examination of right wrist revealed range of motion: Extension 45 degrees, flexion of 45 degrees, radial deviation of 20 degrees, and ulnar deviation of 30 degrees. Tinel's sign was positive on the right for carpal tunnel and Phalen's sign was positive on the right for carpal tunnel. There were no medications provided. The treatment plan is for 12 to 18 sessions

of physical therapy. The rationale for the request was not provided. The Request for Authorization form was submitted on 08/22/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

12-18 sessions of physical therapy: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine guidelines Page(s): 99.

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

Decision rationale: The request for Twelve to eighteen sessions of physical therapy is not medically necessary. The California MTUS guidelines recommend allowing for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus participation in an active self-directed home physical medicine program. The guidelines recommend 9-10 sessions of physical therapy over 8 weeks. There is a lack of documentation indicating the injured worker is compliant with participation in a home exercise program. The site of therapy is not specified. Therefore the request for physical therapy three times a week times three weeks of right shoulder is not medically necessary.

Paraffin wax unit for home use: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation official disability guidelines

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

Decision rationale: The request for Paraffin wax unit for home use is not medically necessary. The Official Disability Guidelines states Paraffin wax baths are recommended as an option for arthritic hands if used as an adjunct to a program of evidence-based conservative care (exercise). According to a Cochrane review, paraffin wax baths combined with exercises can be recommended for beneficial short-term effects for arthritic hands. There is no documentation the patient is diagnosed with arthritis. There is a lack of documentation indicating the injured worker is compliant with participation in a home exercise program. The request is not supported by the evidenced based guidelines. Therefore the request is not medically necessary.