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| Case Number: | CM14-0051079 | | |
| Date Assigned: | 06/23/2014 | Date of Injury: | 03/24/2013 |
| Decision Date: | 08/19/2014 | UR Denial Date: | 02/25/2014 |
| Priority: | Standard | Application Received: | 03/21/2014 |

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 Internal Medicine and is licensed to practice in Arizona. 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:

This claimant has a date of injury on March 23, 2013. She was cleaning an ice cream machine and it was activated causing pain to her right upper extremity. The industrial clinic physician that assessed her stated the patient complained of right upper extremity pain that even affected her sleep. On exam, I believe (barely legible) it states that she has a limited range of motion of the right wrist- See Exam Form. Yet, this form is not in the record. There is a recommendation that she undergo evaluation with x-rays, and MRI's of the wrist, elbow and cervical spine, upper extremity & cervical spine, EMG/NCV (electrodiagnostic assessment), and ESWT (extracorporeal shockwave therapy). There are no records to indicate if any of these evaluations were completed. The physician diagnoses were right Carpal Tunnel Syndrome, right DeQuervain's Tenosynovitis, right forearm Tendinitis, stress/anxiety due to the trauma, and cervical ??? (Illegible) The previous reviewer stated that the patient had completed 12 sessions of physical therapy. There are no notes from the physical therapist and there are no follow up notes from the ordering physician; thus it is unclear if the patient benefited from the physical therapy and whether there were any documented limitations. Additionally, there were no notes discussing the rationale behind the request for Functional Capacity Evaluation (FCE), nor was there any discussion addressing what type of work the complainant was able to do at her employment. It was stated that she was on a modified program.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physiotherapy to the right upper extremity, twice weekly for six weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 48.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 273, Chronic Pain Treatment Guidelines 8, California Code of Regulations, Section 9792.2. Carpal Tunnel Syndrome, Physical Medicine Page(s): 15,98.

Decision rationale: The specific reason for the additional physical therapy (PT) was not mentioned, though it would presumably be for the mentioned diagnoses of Carpal Tunnel Syndrome (CTS), DeQuervain's Tendonitis, forearm and wrist pain. There is limited evidence for effectiveness with PT for CTS. CTS should not result in extended time off work especially when CT release surgery is a relatively simple operation that also should not require extended multiple therapy office visits for recovery. PT is not directly mentioned for DeQuervain's Tendonitis, stating that conservative treatment, including splinting, injections should be tried, and if failed, referral to a surgeon is warranted. For overall wrist and hand pain of a chronic nature, the Chronic Pain Medical Treatment Guidelines states there should be fading of physical therapy treatment frequency from up to three visits per week to 1 or less and that for medical treatment (nonsurgical), ten visits over eight weeks could be allowed. This number of PT visits has been reached and there is no supporting documentation given to warrant additional PT. Thus, the request for Physiotherapy to the right upper extremity, twice weekly for six weeks, is not medically necessary or appropriate.

Functional capacity Evaluation for the right upper extremity: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 48.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines .C.CR 9792.20 - 9792.26, Functional Improvement Measures Page(s): 48.

Decision rationale: Generally doing Functional Capacity Evaluations (FCE) can be helpful and are recommended in certain situations. The importance of an assessment is to have a measure that can be used repeatedly over the course of treatment to demonstrate improvement of function, or maintenance of function that would otherwise deteriorate. Some of the categories that can be assessed include work functions and or activities of daily living, physical impairments, and overall quality of life. The need for a FCE has not been established in these medical records. The documentation is skimpy. It is not known if some of the records that could justify this were omitted, or perhaps the documentation was never completed. Thus, this request for a Functional capacity evaluation for the right upper extremity is not medically necessary or appropriate.