

Case Number:	CM14-0188949		
Date Assigned:	11/19/2014	Date of Injury:	10/04/2011
Decision Date:	01/07/2015	UR Denial Date:	11/06/2014
Priority:	Standard	Application Received:	11/12/2014

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 Physical Medicine & Rehabilitation, has a subspecialty in Pain Medicine, Spinal Cord Medicine and is licensed to practice in Massachusetts. 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 claimant has a history of a work injury occurring on 10/04/11 while working as a receptionist. She continues to be treated for bilateral wrist and upper extremity pain. Treatments have included multiple upper extremity nerve release surgeries. She has had chiropractic care and physical therapy. She was evaluated for another course of physical therapy on 08/26/14. Pain was rated at 7/10. Prior treatments had included physical therapy with limited benefit and an injection which had not helped. There was positive left shoulder impingement testing. She had decreased shoulder and wrist range of motion. As of 10/15/14 she had completed eight of 10 treatment sessions. Pain was again rated at 7/10. There had been some benefit with cervical traction. She was seen by the requesting provider on 09/25/14. She was noted to be right-hand dominant. She was having left shoulder, left elbow, and bilateral wrist pain. Pain was rated at 5-7/10. Physical examination findings included left shoulder, left elbow, and bilateral wrist tenderness with decreased range of motion. Tinel testing was positive at the wrist and elbow bilaterally. There is reference to physical therapy as having aggravated her symptoms. Recommendations included restarting physical therapy and assessing the claimant for an ergonomic workstation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional physical therapy for the left shoulder and bilateral upper extremities, 8 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 10 Elbow Disorders (Revised 2007), Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 201-205, Chronic Pain Treatment Guidelines Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm, Wrist & Hand (Acute & Chronic), Elbow (Acute & Chronic), Harris J. Occupational Medicine Practice Guidelines, 2nd edition, pages 201-205, 263-266

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain, Physical medicine treatment. (2) Preface, Physical Therapy Guidelines.

Decision rationale: The claimant is more than 2 years status post work-related injury and continues to be treated for bilateral wrist and upper extremity pain. Treatments have included multiple courses of physical therapy with limited benefit. In terms of physical therapy treatment for chronic pain, compliance with a home exercise program would be expected and would not require continued skilled physical therapy oversight. Providing additional skilled physical therapy services would not reflect a fading of treatment frequency and would promote dependence on therapy provided treatments. The claimant has no other identified impairment that would preclude her from performing such a program. Therefore additional physical therapy is not medically necessary.

Ergonomic work station evaluation: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints. Decision based on Non-MTUS Citation Harris J. Occupational Medicine Practice Guidelines, 2nd edition, pages 263-266

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (1) Carpal Tunnel Syndrome, (Acute & Chronic), Ergonomic interventions (2) Neck and Upper Back (Acute & Chronic), Ergonomics

Decision rationale: The claimant is more than 2 years status post work-related injury and continues to be treated for bilateral wrist and upper extremity pain. Treatments have included multiple courses of physical therapy with limited benefit. Guidelines state that, although ergonomic interventions are under study, there is some positive evidence regarding the effect of ergonomic keyboards on pain relief and hand function. Decreased trapezius loading and symptoms secondary to ergonomic intervention has been studied and is supported. Therefore the requested ergonomic work station evaluation is medically necessary.