

Case Number:	CM15-0004200		
Date Assigned:	01/15/2015	Date of Injury:	07/10/2013
Decision Date:	03/17/2015	UR Denial Date:	12/22/2014
Priority:	Standard	Application Received:	01/08/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California, New York, Florida

Certification(s)/Specialty: Internal Medicine, Pulmonary Disease, Critical Care Medicine

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 57-year-old female who reported an injury on 07/10/2013. The mechanism of injury was not stated. The current diagnoses include right knee pain, right knee medial meniscus tear, right knee chondromalacia, and instigation of repetitive strain injury to the right knee. The injured worker presented on 11/10/2014 for a followup evaluation. The injured worker was given a Hyalgan injection into the right knee. Recommendations at that time included a followup evaluation on 12/10/2014. A Request for Authorization form was then submitted on 12/11/2014 for additional physical therapy for the right upper extremity. While there was no physician progress report submitted on the requesting date, the latest physical therapy note submitted for this review is documented on 08/26/2014. It was noted that the injured worker was diagnosed with flexor tendinitis and possible carpal tunnel syndrome. The injured worker had completed 8 sessions of physical therapy. Upon examination, there was diminished range of motion of the bilateral hands/wrists with diminished motor strength on the right.

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional physical therapy 2x4 for the right wrist/hand: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 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. There is no documentation of a significant functional improvement following the initial course of treatment. There was no recent physician progress report submitted for review with a comprehensive physical examination of the wrist/hand. Given the above, the medical necessity has not been established in this case. As such, the request is not medically appropriate.