

Case Number:	CM15-0107192		
Date Assigned:	06/11/2015	Date of Injury:	07/23/2013
Decision Date:	07/15/2015	UR Denial Date:	05/11/2015
Priority:	Standard	Application Received:	06/03/2015

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
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 62-year-old male, who sustained an industrial injury on 07/23/2013. He has reported subsequent neck, bilateral upper extremity and bilateral knee pain and was diagnosed with degenerative joint disease of the bilateral knees, sprain/strain of the cervical spine with disc bulges and moderate bilateral carpal tunnel syndrome. Treatment to date has included oral pain medication, physical therapy and rest. In a progress note dated 01/02/2015, the injured worker complained of neck pain with radicular symptoms into the right and left arm with numbness and weakness to the arms and hands, ongoing right thumb pain and bilateral knee pain with difficulty walking on uneven terrain and climbing. Objective findings were notable for decreased range of motion of the cervical spine, positive foraminal compression and Spurling's tests, tightness and spasm in the trapezius, sternocleidomastoid and straps muscle right and left, positive McMurray's test of the bilateral knees and chondromalacia patellar compression test and medial joint line tenderness of the bilateral knees. A request for authorization of right trigger thumb Cortisone injection and 18 sessions of physical therapy (3x6) of the cervical spine, right hand and shoulder was submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Trigger Thumb Cortisone Injection: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): Chapter 11- Forearm, Wrist, and Hand Complaints, Treatment, page 265.

Decision rationale: Per Guidelines, corticosteroid injections may produce short-term pain relief; however, in the long-term, they are less effective in providing pain relief and benefit with high recurrence rates when compared to physical therapy in a functional restoration approach. In addition, cortisone injections have some risks of tendon fraying and even rupture which may not be appropriate in certain patient. Corticosteroid injections may be recommended for diagnoses of de Quervain's tenosynovitis, Trigger finger, and in mild to moderate cases of CTS after failed treatment trial of splinting and medications; however, this has not been clinically demonstrated here. Corticosteroid injections are not recommended for all chronic hand, wrist and forearm disorders and repeated or frequent injections have not shown evidenced-based efficacy. Submitted reports have not adequately demonstrated the indication or necessity to support for this request. The Right Trigger Thumb Cortisone Injection is not medically necessary and appropriate.

Physical Therapy 3x6 to Cervical Spine, Right Hand and Shoulder: 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 Therapy, pages 98-99.

Decision rationale: Physical therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. However, there is no clear measurable evidence of progress with the PT treatment already rendered including milestones of increased ROM, strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints, clinical findings, and functional status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. The Chronic Pain Guidelines allow for visits of physical therapy with fading of treatment to an independent self-directed home program. It appears the employee has received significant therapy sessions without demonstrated evidence of functional improvement to allow for additional therapy treatments. There is no report of acute flare-up, new injuries, or change in symptom or clinical findings to support for formal PT in a patient that has been instructed on a home exercise program for this chronic injury. Submitted reports have not adequately demonstrated the indication to support further physical therapy when prior treatment rendered has not resulted in any functional benefit. The Physical Therapy 3x6 to Cervical Spine, Right Hand and Shoulder is not medically necessary and appropriate.