

Case Number:	CM15-0191765		
Date Assigned:	10/05/2015	Date of Injury:	02/24/2014
Decision Date:	11/12/2015	UR Denial Date:	09/09/2015
Priority:	Standard	Application Received:	09/29/2015

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 27 year old female who sustained an industrial injury on 02-24-2014. Medical records indicated the worker was treated for right wrist strain. Other orthopedic complaints are bilateral shoulder and arm pain, bilateral forearm pain and left wrist-hand complaints. In the provider notes (03-13-2015 to 08-19-2015), the injured worker complains of constant right wrist pain radiating to upper arm. In notes of 06-29-2015, the right wrist and hand pain is described as sharp, non-radiating, present 100% of the time and interferes with her ability to carry, grab, grip forcefully, lightly or repetitively, lift, pull, and push. On exam, the worker has tenderness of the right wrist, and her light touch sensation is intact in the right fingertip, right distal thumb and right small tip of the fingers. She has no decreased mobility. She denied ever having had either x-rays or MRI of the left hand. In the provider notes of 08-19-2015, it is stated that upper extremity electrodiagnostic results of 05-2015 have not been provided. The provider requested authorization to repeat the test. Her prior physical therapy session was 05-2015 and the sessions helped her manage pain (note 08-19-2015). A request for authorization was submitted for: EMG for the right upper extremity and Physical therapy 2x6 weeks for the right wrist, AS off 08-19-2015, the worker is on temporary disability status for 6 weeks. A utilization review decision 09-09-2015, non-certified both requests.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG for the right upper extremity: Upheld

Claims Administrator guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Special Studies.

Decision rationale: Review indicates the patient underwent recent EMG study in May 2015 now with request to repeat the study. Per MTUS Guidelines, without specific symptoms or neurological compromise consistent with radiculopathy, foraminal or spinal stenosis, or entrapment syndrome, medical necessity for EMG and NCV have not been established. Submitted reports have not demonstrated any symptoms or clinical findings to suggest any cervical radiculopathy or entrapment syndrome, only with continued diffuse pain complaints without specific consistent myotomal or dermatomal correlation to support for repeating the electrodiagnostics without any report of new injury, acute flare-up, or red-flag conditions. The EMG for the right upper extremity is not medically necessary and appropriate.

Physical therapy 2x6 weeks for the right wrist: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

Decision rationale: Time-limited care plan with specific defined goals, assessment of functional benefit with modification of ongoing treatment based upon the patients progress in meeting those goals and the providers continued monitoring of successful outcome is stressed by MTUS guidelines. 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. Submitted reports have no acute flare-up or specific physical limitations to support for physical/ occupational therapy. The Chronic Pain Guidelines allow for 9-10 visits of therapy with fading of treatment to an independent self-directed home program. It is unclear how many PT sessions have been completed; however, the submitted reports have not identified clear specific functional improvement in ADLs, functional status, or decrease in medication and medical utilization nor have there been a change in neurological compromise or red-flag findings demonstrated from the formal physical therapy already rendered to support further treatment for this February 2014 injury. Submitted reports have also not adequately demonstrated the indication to support for excessive quantity of PT sessions without extenuating circumstances established beyond the guidelines. The Physical therapy 2x6 weeks for the right wrist is not medically necessary and appropriate.

