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| Case Number: | CM15-0197818 | | |
| Date Assigned: | 10/13/2015 | Date of Injury: | 05/31/2012 |
| Decision Date: | 11/20/2015 | UR Denial Date: | 10/07/2015 |
| Priority: | Standard | Application Received: | 10/08/2015 |

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: New York
 Certification(s)/Specialty: Internal 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 an 80 year old female who sustained an industrial injury on 05-31-2012. According to a progress report dated 09-29-2015, the injured worker reported pain in the right upper extremity and elbow, specifically on the medial and lateral epicondyles. She reported "significant" pain in the extensor compartment on the right upper extremity and forearm and pain in the volar aspect of the right upper extremity and wrist. She was having memory loss issues in addition to balance issues. Physical examination revealed right proximal forearm atrophy just distal to the medial epicondyle. There was positive pain on palpation on the right lateral epicondyle as well as the medial epicondyle. There was positive swelling noted as well, that was "significant". Positive pain on palpation over the first dorsal wrist extensor compartment was noted. Tinel's sign over the Guyon's canal and cubital tunnel bilaterally was negative. There was no evidence of any dorsal or volar wrist mass noted bilateral or evidence of dorsal or volar forearm masses bilaterally. Diagnoses included status post right rotator cuff repair, status post right carpal tunnel decompression on 01-18-2014, status post right cubital tunnel release on 01-18-2014 and status post right lateral common extensor tendon repair on 05-14-2014, chronic bilateral tinnitus, vertigo, memory loss, balance problems, history of cephalohematoma and persistent chronic headaches. The treatment plan included 6 physical therapy sessions for the right upper extremity. The injured worker was off work secondary to her multiple medical issues. Follow up was indicated in 6 weeks. Documentation submitted for review indicates that the injured worker had prior physical therapy but was unclear regarding how many sessions had been completed. On 10-07-2015, Utilization Review non-certified the request for outpatient

physical therapy evaluation and outpatient physical therapy to the right upper extremity, (right elbow-right wrist) three visits per week for two weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient physical therapy evaluation and outpatient physical therapy to the right upper extremity, (right elbow/right wrist), three visits per week for two weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Functional improvement measures, Physical Medicine.

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

Decision rationale: According to the California MTUS Treatment guidelines, physical therapy (PT) is indicated for the treatment of musculoskeletal pain. 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. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Per ODG, patients should be formally assessed after a "6-visit trial" to see progress made by patient. When the duration and/or number of visits have exceeded the guidelines, exceptional factors should be documented. Additional treatment would be assessed based on functional improvement and appropriate goals for additional treatment. In this case, the patient has received prior physical therapy to the right upper extremity and there is no documentation indicating that she had a defined functional improvement in her condition. There is no specific indication for the additional physical therapy sessions (3 visits per week x 2 weeks) requested. Medical necessity for the additional PT visits is not established. The requested services are not medically necessary.