

Case Number:	CM15-0198991		
Date Assigned:	10/14/2015	Date of Injury:	12/10/2012
Decision Date:	11/20/2015	UR Denial Date:	10/01/2015
Priority:	Standard	Application Received:	10/09/2015

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 58 year old female who sustained an industrial injury on 12-10-2012. A review of medical records indicates the injured worker is being treated for chronic cervical strain, cervical disc herniation with bilateral upper extremity radiculopathy, chronic lumbar strain, bilateral carpal tunnel syndrome, and status post right carpal tunnel release. Medical records dated 9-11-2015 noted persistent ongoing pain in the neck and mid back rated an 8 out of 10. Both were frequent and radiating to the right shoulder. She rates her right wrist and hand pain an 8 out of 10. Pain was worsening and radiated all the way up to her elbows. With medications, pain goes down to a 5 out 10 and allows her to do basic activities of daily living. Physical examination noted loss of range of motion to the cervical spine. There was pain to the mid back. There was tenderness over the left hand. There was decreased sensation at the medial aspect of the right hand. Treatment has included surgery, Naproxen, and physical therapy. Utilization review form dated 10-1-2015 noncertified 6 sessions of physical therapy for the right wrists.

IMR ISSUES, DECISIONS AND RATIONALES

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

6 sessions of physical therapy for the right wrists: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment 2009, Section(s): Carpal Tunnel Syndrome.

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

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 2012 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 6 sessions of physical therapy for the right wrists is not medically necessary and appropriate.