

Case Number:	CM15-0037678		
Date Assigned:	03/06/2015	Date of Injury:	06/18/2012
Decision Date:	07/01/2015	UR Denial Date:	02/13/2015
Priority:	Standard	Application Received:	02/27/2015

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 a 53 year old female, who sustained an industrial injury on 06/18/2012. According to a progress report dated 01/21/2015, the injured worker had wrist arthroscopy scheduled for 03/24/2014 and developed sympathetic dystrophy along the hand, arm and shoulders. She developed a stiff shoulder. She had persistent pain, numbness, tingling and swelling. She could not do anything with the right hand. She primarily used her left hand as a result of the injury. Electromyography in 2012 was unremarkable. Bone scan was completed showing positive sympathetic dystrophy. Diagnoses included wrist joint inflammation with TFCC ligament tear, extensor carpi ulnaris tenosynovitis, ganglion cyst along the scapholunate area, TFCC ligament radial tear with median nerve inflammation noted by MRI, major causalgia and chronic regional pain syndrome involving shoulder, elbow, wrist and hand, element of depression, sleep and stress and a stiff shoulder on the right. The injured worker was currently not working. The treatment plan included additional physical therapy. Treatment to date has included medications, 24 sessions of physical therapy and cognitive behavioral therapy. Currently under review is the request for physical therapy 1 time a week for 12 weeks for the right shoulder and wrist.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 1xWk x 12 Wks for the right shoulder and wrist: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm, Wrist and Hand Chapter, Physical/Occupational therapy guidelines; Physical therapy guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy Page(s): 98. Decision based on Non-MTUS Citation Official Disability Guidelines: Physical Therapy.

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. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assisting devices. In this case, the patient has completed a total of 24 physical therapy sessions. Per ODG, the maximum number of sessions for her condition would be 18 visits over a 6-week period. There is no documentation indicating that she had a defined functional improvement in her condition. There is no specific indication for the requested additional PT sessions. Medical necessity for the requested item has not been established. The requested item is not medically necessary.