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| Case Number: | CM15-0056388 | | |
| Date Assigned: | 04/01/2015 | Date of Injury: | 08/01/2005 |
| Decision Date: | 05/07/2015 | UR Denial Date: | 02/24/2015 |
| Priority: | Standard | Application Received: | 03/24/2015 |

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, Indiana, Oregon
Certification(s)/Specialty: Orthopedic Surgery

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 52 year old female, who sustained an industrial injury on 8/1/05. The injured worker notes resolution of the tingling and numbness in the hand and surgery. The impressions have included history of bilateral thoracic outlet decompression (2003) with bilateral revisions (2011); history of bilateral ulnar nerve transpositions (2006) with right ulnar nerve revision (2007) and status post left carpal tunnel release on 1/21/2015. Treatment to date has included hip core decompression surgeries times two; hip replacement times three in 2008, 2009 and 2010; bilateral lunar nerve transpositions 2006 with right ulnar nerve revision 2007; right shoulder subarcomial decompression 2012; status post left carpal tunnel release on 1/2/1/15; dexamethasone injections performed to both carpal tunnels; bilateral contoured wrist splints; therapy and medications. The request was for Physical therapy 2 x 3 for the thoracic spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 2 x 3 for the thoracic spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines, Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: CA MTUS/Chronic Pain Medical Treatment Guidelines, Physical Medicine, page 98-99 recommend the following for non-surgical musculoskeletal conditions, Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2) 8-10 visits over 4 week. The chart note 2/6/2015 does not document any subjective or objective findings in the thoracic spine. As the requested physical therapy exceeds the recommendation, the service is not medically necessary.