

Case Number:	CM15-0082877		
Date Assigned:	05/06/2015	Date of Injury:	04/19/2013
Decision Date:	06/03/2015	UR Denial Date:	04/02/2015
Priority:	Standard	Application Received:	04/30/2015

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 31 year old female who sustained an industrial injury 4/19/13. The injured worker was diagnosed as having right shoulder impingement/bursitis, right shoulder arthrosis, right elbow cubital tunnel syndrome, right elbow lateral epicondylitis, bilateral carpal tunnel syndrome and right wrist De Quervain syndrome. Currently, the injured worker reported complaints of bilateral hand/wrist pain, right should and right elbow pain. Previous treatments included physical therapy and non-steroidal anti-inflammatory drugs. Magnetic resonance imaging performed on 12/29/14 revealed a moderate rotator cuff tendinosis without subacromial and acromioclavicular joint degenerative change without full-thickness tear and superior labral anterior posterior lesion. The injured worker rated her bilateral wrist pain at 3/10 and the shoulder pain at an 8/10. Physical examination performed 2/26/15 revealed the lateral epicondyle was tender to palpation, bilateral wrists and hands were not noted to be tender upon palpation or with range of motion. The plan of care was for medication prescriptions and physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 2 times a week for 4 weeks for right shoulder, elbow and wrist: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Pain, Suffering and the Restoration of Function Chapter, page 114 Official Disability Guidelines (ODG), Shoulder, Elbow and CTS Chapters.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy, pages 98-99.

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 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 Physical therapy 2 times a week for 4 weeks for right shoulder, elbow and wrist is not medically necessary and appropriate.

Ketoprofen cream 20%: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 112-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, page(s) 111-113.

Decision rationale: Per MTUS Chronic Pain Guidelines, the efficacy in clinical trials for topical analgesic treatment modality has been inconsistent and most studies are small and of short duration. These medications may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. There is little evidence to utilize topical compound analgesic over oral NSAIDs or other pain relievers for a patient with spinal and multiple joint pain without contraindication in taking oral medications. Submitted reports have not adequately demonstrated the indication or medical need for this topical analgesic for this chronic injury without documented functional improvement from treatment already rendered. The Ketoprofen cream 20% is not medically necessary and appropriate.

