

Case Number:	CM14-0118325		
Date Assigned:	08/06/2014	Date of Injury:	06/07/2008
Decision Date:	10/20/2014	UR Denial Date:	06/27/2014
Priority:	Standard	Application Received:	07/28/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain Management and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a patient with a date of injury of June 7, 2008. A utilization review determination dated June 27, 2014 recommends noncertification of physical therapy for the left hand. Modified certification was recommended since the patient has completed 6 sessions of physical therapy. Therefore, modified certification was recommended to allow for 6 additional sessions of physical therapy followed by reevaluation for improvement in symptomatology and function. A progress note dated June 26, 2014 identifies subjective complaints of low back pain. Additionally, the patient is status post carpal tunnel release surgery performed 5 weeks ago and has not yet started physical therapy. Physical examination identifies decreased grip strength with spasm and tenderness noted in the paravertebral muscles of the lumbar spine with decreased range of motion. The diagnoses include status post carpal tunnel release surgery and lumbosacral radiculopathy. The treatment plan recommends Marco 5 mg #30, physical therapy X 12 directed towards the left wrist and hand, and an MRI of the lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy three (3) times a week times six (6) weeks left Hand: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 15.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm, Wrist, and Hand Chapter, Physical Therapy

Decision rationale: Regarding the request for additional physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. ODG recommends 3 therapy visits for the treatment of carpal tunnel syndrome. Within the documentation available for review, there is no documentation of specific objective functional deficits that cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised therapy. Furthermore, the request exceeds the amount of PT recommended by ODG and, unfortunately, there is no provision for modification of the current request. In light of the above issues, the currently requested additional physical therapy is not medically necessary.