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| Case Number: | CM14-0212983 | | |
| Date Assigned: | 12/30/2014 | Date of Injury: | 10/01/2002 |
| Decision Date: | 02/26/2015 | UR Denial Date: | 11/19/2014 |
| Priority: | Standard | Application Received: | 12/19/2014 |

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. 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 & Rehabn

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 patient sustained an injury on 10/1/2002 while employed by [REDACTED]. Request(s) under consideration include Physical therapy bilateral upper extremities and cervical spine. Diagnoses include cervical strain, bilateral carpal tunnel syndrome and bilateral lateral epicondylitis s/p bilateral lateral epicondylectomy and right shoulder arthroscopy. Conservative care has included medications, therapy modalities, and modified activities/rest. The patient continues to treat for chronic ongoing symptom complaints. Report from the provider noted continued bilateral upper extremity pain with numbness in the hands and fingers. Exam showed right shoulder and trapezius tenderness; slightly restricted range with discomfort; left elbow with mild edema over proximal forearm extensors; bilateral hand/wrist with ganglion cyst; slight grip strength and restricted range. The request(s) for Physical therapy bilateral upper extremities and cervical spine were non-certified citing guidelines criteria and lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy bilateral upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

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

Decision rationale: This patient sustained an injury on 10/1/2002 while employed by [REDACTED]. Request(s) under consideration include Physical therapy bilateral upper extremities and cervical spine. Diagnoses include cervical strain, bilateral carpal tunnel syndrome and bilateral lateral epicondylitis s/p bilateral lateral epicondylectomy and right shoulder arthroscopy. Conservative care has included medications, therapy modalities, and modified activities/rest. The patient continues to treat for chronic ongoing symptom complaints. Report from the provider noted continued bilateral upper extremity pain with numbness in the hands and fingers. Exam showed right shoulder and trapezius tenderness; slightly restricted range with discomfort; left elbow with mild edema over proximal forearm extensors; bilateral hand/wrist with ganglion cyst; slight grip strength and restricted range. The request(s) for Physical therapy bilateral upper extremities and cervical spine were non-certified. 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 work 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 9-10 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 2002 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 bilateral upper extremities are not medically necessary and appropriate.

Physical therapy for the cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

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

Decision rationale: This patient sustained an injury on 10/1/2002 while employed by [REDACTED]. Request(s) under consideration include Physical therapy bilateral upper extremities and cervical spine. Diagnoses include cervical strain, bilateral carpal tunnel syndrome and bilateral lateral epicondylitis s/p bilateral lateral epicondylectomy and right shoulder arthroscopy. Conservative care has included medications, therapy modalities, and modified activities/rest. The patient continues to treat for chronic ongoing symptom complaints. Report from the provider noted

continued bilateral upper extremity pain with numbness in the hands and fingers. Exam showed right shoulder and trapezius tenderness; slightly restricted range with discomfort; left elbow with mild edema over proximal forearm extensors; bilateral hand/wrist with ganglion cyst; slight grip strength and restricted range. The request(s) for Physical therapy bilateral upper extremities and cervical spine were non-certified. 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 work 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 9-10 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 for the cervical spine is not medically necessary and appropriate.