

Case Number:	CM14-0215715		
Date Assigned:	01/05/2015	Date of Injury:	01/18/2008
Decision Date:	02/24/2015	UR Denial Date:	11/20/2014
Priority:	Standard	Application Received:	12/23/2014

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, Indiana, 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 (IW) is a year-old man with a date of injury of January 18, 2008. The mechanism of injury was not documented in the medical record. The injured worker's working diagnoses are cervical spine disc bulges; lumbar spine disc bulges with radiculopathy; possible right shoulder internal derangement; possible left shoulder internal derangement; right wrist surgery; left carpal tunnel syndrome; right medial finder surgery; and other problems unrelated to current evaluation. There is a sole progress report in the medical record dated October 29, 2014. According to the documentation, using a check box format, the IW reports pain in the neck, lower back, right shoulder, left shoulder, right hand/wrist, left hand/wrist, and left knee/ The only objective documentation reveals light touch sensation to the right lateral shoulder intact; right thumb dorsal web intact; right long tip intact; and right small tip intact. Medications were not documented. A single progress note was present in the medical record. A treatment plan was not documented. Prior physical therapy (PT) was not documented. It is unclear if the IW had prior PT due to lack of documentation. If so, there was no evidence of objective functional improvement associated with prior PT. There were no physical therapy progress notes in the medical record. The treating physician did not provide a clinical rational or indication as to why the IW needs PT. There was no physical examination of the right wrist or cervical spine. The current request is for physical therapy 2 times a week for 6 weeks for the right wrist and cervical spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 2x6 for the right wrist and cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm, Wrist & Hand; Low Back

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Neck/Wrist Section, Physical Therapy

Decision rationale: Per the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, patients should be formally assessed after a six visit clinical trial to see if the patient is moving in a positive direction, no direction or negative direction (prior to continuing with physical therapy). When treatment duration and or number of visits exceeds of the guideline, exceptional factors should be noted. In this case, the injured worker's working diagnoses are cervical spine disc bulges; lumbar spine disc bulges with radiculopathy; possible right shoulder internal derangement; possible left shoulder internal derangement; right wrist surgery; left carpal tunnel syndrome; right medial finger surgery; and other problems unrelated to current evaluation. The documentation contains a single progress note in the medical record. The date of injury is January 18, 2008. The single progress note does not contain evidence of prior physical therapy, physical therapy progress notes, physical therapy documentation with objective functional improvement, or a clinical rationale as to why the injured worker needs additional physical therapy. Additional documentation needs to be obtained with evidence of prior physical therapy in a 9-year-old injury. Alternatively, if the injured worker did not receive physical therapy, the guidelines permit a six visit clinical trial. The treating physician requested 12 physical therapy sessions. This is in excess of guideline recommendations. Consequently, absent clinical documentation with evidence of prior physical therapy and objective functional improvement, physical therapy progress notes along with evidence of compelling clinical facts indicating additional physical therapy is warranted, physical therapy two times per week for six weeks to the right wrist and cervical spine is not medically necessary.