

Case Number:	CM15-0124496		
Date Assigned:	07/09/2015	Date of Injury:	01/06/1994
Decision Date:	08/05/2015	UR Denial Date:	05/26/2015
Priority:	Standard	Application Received:	06/29/2015

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 (IW) is a 55 year old female who sustained an industrial injury on 01/06/1994. She reported injury to the wrist, hand, shoulder and cervical disc. The injured worker was diagnosed as having deQuervain's tenosynovitis, bilateral wrists, situation post 1st dorsal compartment decompression bilateral wrists; cervical spine sprain/strain; possible cervical spine disc injury; rule out cervical spine radiculopathy; bilateral shoulder sprain/strain; impingement syndrome, bilateral shoulders; overuse syndrome, bilateral upper extremity; rule out carpal tunnel syndrome, bilateral upper extremity. Treatment to date has included nonsteroidal anti-inflammatory drugs, wrist braces, and recommended to have carpal tunnel release. Currently, the injured worker complains of pain in the posterior neck, throbbing and burning. Pain is constant with different severity based on activity. There is pain on palpation of the acromioclavicular joint both left and right, pain on palpation of the biceps tendon on the right, and pain in the deltoid on the right. Shoulder range of motion and motor strength are unremarkable, as are deep tendon reflexes. Pinwheel sharp/dull differentiation was normal both left and right. Impingement test was positive both left and right. There was slight pain in the lateral epicondyle on the right, and there was pain to palpation on the right wrist. The treatment plan includes medications for pain, and physical therapy. A request for authorization is made for the following: Physical Therapy for the Right Wrist, 2 times weekly for 4 wks., 8 sessions, as an outpatient.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy for the Right Wrist, 2 times weekly for 4 wks., 8 sessions, as an outpatient: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints, Chronic Pain Treatment Guidelines Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines: Neck & Upper Back (acute & chronic); Shoulder (acute & chronic); Forearm Wrist & Hand (acute & chronic).

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 Permanent & Stationary injury of 1994. 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 right wrist, 2 times weekly for 4 wks., 8 sessions, as an outpatient is not medically necessary and appropriate.