

Case Number:	CM15-0129176		
Date Assigned:	07/15/2015	Date of Injury:	04/15/2014
Decision Date:	08/24/2015	UR Denial Date:	06/11/2015
Priority:	Standard	Application Received:	07/03/2015

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, Hawaii

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 61 year old male who sustained an industrial injury on 04/15/2014. The mechanism of injury and initial report of injury are not found in the records reviewed. The worker did injure his left wrist. The injured worker was diagnosed as having- Thoracic disc protrusion-Thoracic myospasm-Left shoulder impingement syndrome-Left shoulder myofasciitis-Left wrist internal derangement-Left wrist tenosynovitis-Closed fracture of wrist-Nervousness-Psych component. Treatment to date has included radiographic imaging, physical therapy, medications and medication management, and a psychological evaluation. Currently, the injured worker complains of intermittent moderate upper-mid back pain, left shoulder pain that is frequent and mild that becomes moderate, constant moderate sharp, throbbing left wrist pain with muscle spasms. The worker exhibits symptoms of chronic pain, becoming confused easily and failing to follow directions well. On examination, there was no bruising, swelling, atrophy or lesion of the thoracic spine, and there was full range of motion in all planes. The left shoulder was also not bruised, swollen, atrophic, and had no lesion, but the range of motion was slightly decreased in all planes. There was tenderness to palpation and muscle spasm of the anterior shoulder. The left wrist had bruising present. There were disfigured bones present and the ranges of motion are decreased and painful. There is tenderness to palpation of the lateral and medial wrist, and Phalen's causes pain. Tinel's causes pain, reverse Phalen's causes pain, and Finkelstein's cause's pain. A request for authorization was made for the following: 1. Outpatient physical therapy (PT) treatment to the left

arm/wrist two (2) times a week for four (4) weeks 2. Sleep study consultation 3.
Permanent and stationary evaluation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient physical therapy (PT) treatment to the left arm/wrist two (2) times a week for four (4) weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

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

Decision rationale: The patient presents with pain affecting the thoracic spine, left shoulder, left wrist, and sleep disturbance. The current request is for Outpatient physical therapy treatment to the left arm/wrist two (2) times a week for four (4) weeks. The treating physician states in the report dated 6/2/15, "I am referring the patient to Physical therapy 2X4 to address pain and weakness in his left arm and wrist." (39B) The treating physician also documents that physical therapy was requested in February 2015 but it is unclear if the patient completed these visits. The MTUS guidelines state, "They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process" and MTUS only allows 8-10 sessions of physical therapy. In the records provided for review for this case, the treating physician has not documented how many prior physical therapy sessions the patient has completed and if the patient had any functional improvement with physical therapy. There is no documentation of any recent surgery, flare-up, new injury or new diagnosis that would require additional physical therapy and there is no discussion as to why the patient is not currently able to transition to a home exercise program. The current request is not medically necessary.

Sleep study consultation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain chapter, Sleep Study.

Decision rationale: The patient presents with pain affecting the thoracic spine, left shoulder, left wrist, and sleep disturbance. The current request is for Sleep Study Consultation. The treating physician states in the report dated 6/2/15, "As a result of the industrially related pain and/or emotional stressors the patient developed sleep disturbances." (40B) The ODG guidelines state, "Recommended after at least six months of an insomnia complaint (at least four nights a week), unresponsive to behavior intervention and sedative/sleep-promoting medications, and after psychiatric etiology has been excluded. Not recommended for the routine evaluation of transient

insomnia, chronic insomnia, or insomnia associated with psychiatric disorders." In this case, the treating physician has not documented behavior interventions and response to sedative/sleep-promoting medications per guideline recommendations. The current request is not medically necessary.

Permanent and stationary evaluation: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Outcomes and Endpoints Page(s): 8.

Decision rationale: The patient presents with pain affecting the thoracic spine, left shoulder, left wrist, and sleep disturbance. The current request is for Permanent and Stationary Evaluation. The treating physician states in the report dated 6/2/15, "I recommend the patient have a permanent and stationary evaluation." (39B) The MTUS guidelines state "The physician should periodically review the course of treatment of the patient and any information about the etiology of the pain or the patient's state of health." Evaluation of patient, review of reports, and providing a narrative report is part of a normal reporting and monitoring duties to manage patient's care. The current request is medically necessary.