

Case Number:	CM15-0038500		
Date Assigned:	03/09/2015	Date of Injury:	02/26/2011
Decision Date:	04/20/2015	UR Denial Date:	01/29/2015
Priority:	Standard	Application Received:	03/02/2015

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 is a 43 year old female who sustained an industrial injury on 2/26/11. The injured worker reported symptoms in the left shoulder and left upper extremity. The diagnoses included carpal tunnel syndrome wrist (both), cubital tunnel syndrome elbow (left), strain wrist (both), adhesive capsulitis of shoulder, chronic pain and disability with delayed functional recovery, and impingement syndrome shoulder (left). Treatments to date include injections, activity modifications, oral pain medications, home exercises, bracing and massage ball. In a progress note dated 12/23/14 the treating provider reports the injured worker was with "left shoulder pain, left wrist pain and right wrist pain occurs intermittent."

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional occupational therapy for twelve visits for the bilateral hands/wrist: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

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

Decision rationale: The patient presents with left shoulder and bilateral wrist pain rated at 7/10. The request is for ADDITIONAL OCCUPATIONAL THERAPY FOR TWELVE VISITS FOR THE BILATERAL HANDS/WRIST. The request for authorization is dated 01/21/15. The patient has had a MRI of the left shoulder, date unspecified, image documentation is not provided for review. Previous CTS injection worked for about 1.5 years. She does not report any change in location of pain. Patient denies any change in characteristics of pain since last visit. Patient denies any new symptoms, no new injuries since last visit. She has not tried any new form of therapy. Patient's medications include Anaprox, Protonix, Norco, Effexor, Suboxone, Tramadol, Hydrochlorothiazide and Phentermine. The patient is working modified duty. MTUS Chronic Pain Management Guidelines, pages 98, 99 have the following: "Physical Medicine: recommended as indicated below. Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. MTUS guidelines pages 98, 99 states that for Myalgia and myositis, 9-10 visits are recommended over 8 weeks. For Neuralgia, neuritis, and radiculitis, 8-10 visits are recommended." Treater does not provide reason for the request. A short course of occupational therapy would be indicated by guidelines given patient's symptoms. However, per UR letter dated 01/29/15 states "Claimant has previously had 14 sessions." Furthermore, the request for 12 additional sessions of occupational therapy would exceed guideline recommendation for the patient's condition. Therefore, the request IS NOT medically necessary.

Purchase of Dragon keyboard: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 262.

Decision rationale: The patient presents with left shoulder and bilateral wrist pain rated at 7/10. The request is for PURCHASE OF DRAGON KEYBOARD. The request for authorization is dated 01/21/15. The patient has had a MRI of the left shoulder, date unspecified, image documentation is not provided for review. Previous CTS injection worked for about 1.5 years. She does not report any change in location of pain. Patient denies any change in characteristics of pain since last visit. Patient denies any new symptoms, no new injuries since last visit. She has not tried any new form of therapy. Patient's medications include Anaprox, Protonix, Norco, Effexor, Suboxone, Tramadol, Hydrochlorothiazide and Phentermine. The patient is working modified duty. ACOEM page 262 supports ergonomic evaluations and modifications stating: "The clinician may recommend work and activity modifications or ergonomic redesign of the workplace to facilitate recovery and prevent recurrence. The employer's role in accommodating activity limitations and preventing further problems through ergonomic changes is key to hastening the employee's return to full activity." Treater does not provide reason for the request. In this case, the use of a special keyboard may be necessary given the patient's modified work duty. However, the treater does not provide any discussion as to why this keyboard is needed; what kind of problems the patient is having with current keyboard and whether or not the patient is working. Given the lack of any specific discussion regarding the request, it IS NOT medically necessary.

Bilateral wrist injections times 2: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines carpal tunnel chapter on cortisone injection.

Decision rationale: The patient presents with left shoulder and bilateral wrist pain rated at 7/10. The request is for BILATERAL WRIST INJECTIONS X2. The request for authorization is dated 01/21/15. The patient has had a MRI of the left shoulder, date unspecified, image documentation is not provided for review. Previous CTS injection worked for about 1.5 years. She does not report any change in location of pain. Patient denies any change in characteristics of pain since last visit. Patient denies any new symptoms, no new injuries since last visit. She has not tried any new form of therapy. Patient's medications include Anaprox, Protonix, Norco, Effexor, Suboxone, Tramadol, Hydrochlorothiazide and Phentermine. The patient is working modified duty. ODG guidelines under the carpal tunnel chapter on cortisone injection states that it recommends a single injection as an option in conservative treatment. Corticosteroid injections will likely produce significant short-term benefit, but many patients will experience a recurrence of symptoms within several months after injection. Additional injections are only recommended on a case to case basis. Repeat injections are only recommended if there is evidence that a patient who has responded to the first injection is unable to undertake a more definitive surgical procedure at that time. Treater does not provide reason for the request. Per progress report dated, 12/23/14, treater states, "Last cts injection worked for 1.5 years." ODG guidelines recommend repeat injections only for patients unable to undertake a more definitive surgical procedure. In this case, treater does not discuss or document why patient is unable to undertake a surgical procedure. Therefore, given the lack of documentation, the request IS NOT medically necessary.