

Case Number:	CM15-0062488		
Date Assigned:	04/08/2015	Date of Injury:	04/03/2013
Decision Date:	05/08/2015	UR Denial Date:	03/19/2015
Priority:	Standard	Application Received:	04/02/2015

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, Pain Management

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 42-year-old female, who sustained an industrial injury on 4/3/13. She reported initial complaints of neck shoulder, and both wrist pain. The injured worker was diagnosed as having bilateral carpal tunnel syndrome, bilateral shoulder impingement syndrome, cervical spine strain, and lumbar spine strain. Treatment to date has included medication, prior physical therapy sessions (12) for the neck and shoulders, and therapeutic exercises. X-Rays were performed on 2/13/15. Currently, the injured worker complains of worsening neck pain reported as 8/10 with radiating bilateral shoulder pain, increased bilateral hand/wrist pain rated 6/10 with numbness and tingling and decreased grip. Per the primary physician's progress report (PR-2) from 1/20/15, there was decreased range of motion, tenderness to palpation of the trapezius musculature to the cervical spine. The thoracic spine had decreased range of motion. The bilateral shoulders had Hawkins-Kennedy impingement, positive bilaterally, Roo's test positive, bilaterally. The bilateral hand/wrist exam noted tenderness over the wrist flexion extension crease. Durkan's median compression test was positive, bilaterally. Current plan of care included diagnostics (MRI, electroconduction study/ nerve conduction velocity (EMG/NCV) testing, injection, non-steroid anti-inflammatory medication, and physical therapy. The requested treatments include Physical Therapy x 12 and Ibuprofen.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy x 12: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Physical Therapy Guidelines - Shoulder/Neck.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 98-99 of 127. Decision based on Non-MTUS Citation ODG, Low Back Chapter, Physical Medicine.

Decision rationale: Regarding the request for physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course (10 sessions) of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, there is no documentation of specific objective functional improvement with any previous sessions and remaining deficits that cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised therapy. Furthermore, the request exceeds the amount of PT recommended by the CA MTUS and, unfortunately, there is no provision for modification of the current request. In light of the above issues, the currently requested physical therapy is not medically necessary.

Ibuprofen: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 67-72 of 127.

Decision rationale: Regarding the request for ibuprofen, Chronic Pain Medical Treatment Guidelines state that NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Within the documentation available for review, there is no indication that the medication is providing any specific analgesic benefits (in terms of percent pain reduction, or reduction in numeric rating scale) and objective functional improvement to support ongoing use despite the recommendations of the CA MTUS. In the absence of such documentation, the currently requested ibuprofen is not medically necessary.