

Case Number:	CM15-0066952		
Date Assigned:	04/14/2015	Date of Injury:	12/05/2014
Decision Date:	05/15/2015	UR Denial Date:	03/18/2015
Priority:	Standard	Application Received:	04/08/2015

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 45 year old female who sustained an industrial injury on 12/5/14. She has reported initial complaints of hands and arms hurting after working as a packer. The diagnoses have included right carpal tunnel syndrome, pain in joint upper left arm, and sprain/strain of shoulder and upper arm. Treatment to date has included medications, splinting, bracing, diagnostics, and occupational therapy. The diagnostic testing that was performed included X-rays of the bilateral hands and wrists and electromyography (EMG)/ nerve conduction velocity studies (NCV). Currently, as per the physician progress note dated 3/10/15, the injured worker complains of pain in the bilateral wrists rated 5/10 on pain scale. She notes that the left shoulder pain was unchanged and physical therapy has improved the left shoulder pain. The objective findings of the left shoulder exam revealed tenderness in the left trapezius. The bilateral wrists exam revealed tenderness and pain with range of motion. There was no previous therapy sessions noted and the current medications were not documented. Work status was modified duty with restrictions. The physician requested treatments included Physical Therapy 3 times a week for 4 weeks left trapezius and Occupational Therapy 3 times a week for 2 weeks for the bilateral wrists.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy 3x4 left trapezius: Upheld

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 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, Neck and Low Back Chapters, 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 therapy. ODG recommends a trial of therapy. If the trial of 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.

Occupational Therapy 3x2 bilateral wrist: Upheld

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 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, Forearm, Wrist, and Hand Chapter, Physical Medicine.

Decision rationale: Regarding the request for occupational 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 therapy. ODG recommends a trial of therapy. If the trial of 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. In light of the above issues, the currently requested occupational therapy is not medically necessary.