

Case Number:	CM15-0068259		
Date Assigned:	04/15/2015	Date of Injury:	07/01/2014
Decision Date:	05/15/2015	UR Denial Date:	03/11/2015
Priority:	Standard	Application Received:	04/10/2015

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: Texas, California
 Certification(s)/Specialty: Family Practice

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 45 year old male sustained an industrial injury to bilateral upper extremities on 7/1/14. Previous treatment included magnetic resonance imaging, electromyography, physical therapy, acupuncture and medications. In a PR-2 date 2/23/15, the injured worker complained of ongoing pain to bilateral hands and wrists rated 5/10 on the visual analog scale. Physical exam was remarkable for bilateral hands and wrists with instability, weakness and limited range of motion. Current diagnoses included bilateral wrist tenosynovitis and pain in hand joint. The treatment plan included physical therapy three times a week for four weeks, bilateral thumb spica braces, urine toxicology screening, a transcutaneous electrical nerve stimulator unit and a prescription for Ambien. The medication list includes Norco, tramadol, Orphenadrine and Diclofen. Patient has received an unspecified number of PT visits for this injury. The patient's surgical history include right knee surgery. Per the doctor's note dated 3/9/15 patient had complaints of pain in hand and fingers with numbness bilaterally Physical examination of the bilateral hand revealed limited range of motion and no tenderness on palpation or swelling The patient had used wrist brace for this injury The patient has had X-ray of the bilateral hand and wrist with normal findings.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy 3x4 B-Wrist: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITIES GUIDELINES.

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

Decision rationale: Physical Therapy 3x4 B-Wrist. The guidelines cited below state, "allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home physical medicine." Patient has received an unspecified number of PT visits for this injury. Previous conservative therapy notes were not specified in the records provided. The requested additional visits in addition to the previously certified PT sessions are more than recommended by the cited criteria. The records submitted contain no accompanying current PT evaluation for this patient. There was no evidence of ongoing significant progressive functional improvement from the previous PT visits that is documented in the records provided. Previous PT visits notes were not specified in the records provided. There was no objective documented evidence of any significant functional deficits that could be benefitted with additional PT. The guidelines cited, "Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels." A valid rationale as to why remaining rehabilitation cannot be accomplished in the context of an independent exercise program is not specified in the records provided. The medical necessity of the request For Physical Therapy 3x4 B-Wrist is not fully established for this patient. Therefore, the request is not medically necessary.

If Unit And Supplies 30 To 60 Day Rental And Purchase: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (Effective July 18, 2009) Page 118-120 Interferential Current Stimulation (ICS).

Decision rationale: IF Unit and Supplies 30 to 60 Day Rental and Purchase. Per the CA MTUS Chronic Pain Medical Treatment Guidelines, Interferential Current Stimulation (ICS) is "Not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone." Per the cited guideline: "While not recommended as an isolated intervention, Patient selection criteria if Interferential stimulation is to be used anyway: Possibly appropriate for the following conditions if it is documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical medicine: Pain is ineffectively controlled due to diminished effectiveness of medications; or Pain is ineffectively controlled with medications due to side effects; or History of substance abuse; or Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). If those criteria are

met, then a one-month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits. There should be evidence of increased functional improvement, less reported pain and evidence of medication reduction." The records provided do not specify a response to conservative measures such as oral pharmacotherapy in conjunction with rehabilitation efforts for this injury. Patient has received an unspecified number of PT visits for this injury. The records submitted contain no accompanying current PT evaluation for this patient. Detailed response to previous conservative therapy was not specified in the records provided. The previous PT visit notes are not specified in the records provided. Any evidence of diminished effectiveness of medications or intolerance to medications is not specified in the records provided. The medical necessity of the request for IF Unit and Supplies 30 to 60 Day Rental and Purchase is not fully established in this patient. Therefore, the request is not medically necessary.