

Case Number:	CM15-0074144		
Date Assigned:	04/24/2015	Date of Injury:	07/11/2014
Decision Date:	05/21/2015	UR Denial Date:	04/02/2015
Priority:	Standard	Application Received:	04/17/2015

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 58 year old female, who sustained an industrial injury on 07/11/2014. She reported complaints of pain to the right shoulder that radiated down her right arm into the fingers. The injured worker was diagnosed as having right shoulder strain/sprain and rotator cuff tendinitis with adhesive capsulitis, right carpal tunnel syndrome, status post carpal tunnel release with residual median neuropathy and stiffness, cervical strain/sprain, and chronic pain syndrome. Treatment to date has included occupational therapy, status post right carpal tunnel release, electromyogram with nerve conduction velocity, cortisone injection, and physical therapy. In a progress note dated 03/09/2015 the treating physician reports complaints of achy and throbbing right shoulder and right forearm pain with the pain rating of a seven out of ten to the right shoulder, and the pain rating of a six out of ten to the right forearm. The treating physician also noted complaints of throbbing, burning, and shooting pain to the right wrist that is rated a ten out of ten along with tingling and numbness to the right finger. The treating physician requested physical therapy two times a week for three weeks to include the neck, right shoulder, right extremity wrist, and hand noting that the injured worker has ongoing symptoms with the right upper extremity, shoulder, and neck that has not been addressed and also noted that a comprehensive course of physical therapy would be used to address these symptoms and instruct the injured worker on appropriate rehabilitative exercises.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 2x3 weeks to right upper extremity wrist and hand: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy, pages 98-99.

Decision rationale: Physical therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. However, there is no clear measurable evidence of progress with the PT treatment already rendered including milestones of increased ROM, strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints, clinical findings, and functional status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. The Chronic Pain Guidelines allow for visits of physical therapy with fading of treatment to an independent self-directed home program. It appears the employee has received significant therapy sessions without demonstrated evidence of functional improvement to allow for additional therapy treatments. There is no report of acute flare-up, new injuries, or change in symptom or clinical findings to support for formal PT in a patient that has been instructed on a home exercise program for this chronic injury. Submitted reports have not adequately demonstrated the indication to support further physical therapy when prior treatment rendered has not resulted in any functional benefit. The Physical therapy 2x3 weeks to right upper extremity wrist and hand is not medically necessary and appropriate.