

Case Number:	CM13-0021388		
Date Assigned:	06/06/2014	Date of Injury:	08/09/2013
Decision Date:	07/31/2014	UR Denial Date:	08/23/2013
Priority:	Standard	Application Received:	09/09/2013

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Illinois. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 29-year-old female with a reported injury on 08/09/2013. The mechanism of injury was not provided within the clinical notes. The clinical note dated 11/04/2013 reported that the injured worker complained of right upper extremity pain. The physical examination was negative for any significant abnormalities. The injured worker's diagnoses included right wrist De Quervain's; right median neuritis; right flexor tenosynovitis. The injured worker's prescribed medication regimen was not provided within the clinical notes. The provider requested 6 initial physical therapy visits to the injured worker's left hand/wrist; the rationale was not provided within the clinical documentation. The request for authorization was submitted 08/28/2013. The injured worker's previous treatments included physical therapy and medication therapy (i.e., Tylenol).

IMR ISSUES, DECISIONS AND RATIONALES

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

SIX INITIAL PHYSICAL THERAPY VISITS FOR THE LEFT HAND/WRIST, THREE TIMES A WEEK FOR TWO WEEKS, AS AN OUTPATIENT: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

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

Decision rationale: The injured worker complained of right wrist pain. The treating physician's rationale for physical therapy to the left hand/wrist was not provided within the clinical notes. The MTUS Chronic Pain Guidelines recognize active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. Within the provided documentation, an adequate and complete assessment of the injured worker's functional condition is not provided; there is a lack of documentation indicating the injured worker has significant functional deficits. Moreover, the injured worker complained of right upper extremity pain and the request is for physical therapy to the left hand/wrist. Within the medical records provided for review, there is insufficient evidence to determine appropriateness of physical therapy to the left hand and wrist. As such, the request is not medically necessary and appropriate.