

Case Number:	CM13-0026648		
Date Assigned:	11/22/2013	Date of Injury:	11/25/2010
Decision Date:	02/05/2014	UR Denial Date:	08/27/2013
Priority:	Standard	Application Received:	09/19/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Internal Medicine, has a subspecialty in Cardiology and is licensed to practice in Texas. 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 physician 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 patient is a 42-year-old female who reported an injury on 11/25/2010. The mechanism of injury is unknown, but the patient continues to have wrist pain, numbness, difficulty walking, prolonged weight-bearing is difficult, and overall the patient has had continued knee pain, headaches, neck pain, and stiffness. The patient avoids stairs, squatting, kneeling, and prolonged weight-bearing activities. The patient was most recently seen on 10/23/2013, whereupon objective findings noted tenderness to palpation over the knee, and tenderness to palpation over the bilateral paracervical musculature and trapezius with guarding and trigger points were in the trapezius musculature with suboccipital tenderness. Shoulder pressure was positive. Range of motion of the cervical spine was 90 degrees normal with pain at end range.

IMR ISSUES, DECISIONS AND RATIONALES

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

Psychological consultation/evaluation quantity one: 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.

Decision rationale: Under California Medical Treatment Utilization Schedule (MTUS), it states that psychological evaluations are recommended and are generally accepted, well-established

diagnostic procedures not only with selected use in pain problems, but also with more widespread use in chronic pain populations. Diagnostic evaluations should distinguish between conditions that are pre-existing, aggravated by current injury, or work related. However, the clinical information submitted did not indicate the patient was experiencing any psychological symptoms to support the necessity of a consultation/evaluation. As such, the requested service is non-certified.

Functional restoration program quantity eight: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

Decision rationale: Under California Medical Treatment Utilization Schedule (MTUS), it states that chronic pain programs (functional restoration programs) are recommended where there is access to programs with proven successful outcomes, for patients with conditions that put them at risk of delayed recovery. One of the criteria for the general use of multidisciplinary pain management program (as functional restoration program) states that the patient must have a significant loss of ability to function independently resulting from the chronic pain. The patient stated that she is able to perform her activities of daily living; albeit with some difficulty. She is also able to do modified work in accordance with her occupation. However, she has not had a significant loss in the ability to function independently, thus not meeting the criteria for a functional restoration program at this time. As such, the requested service is non-certified.

Flexible wrist brace quantity one: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

Decision rationale: California Medical Treatment Utilization Schedule (MTUS) / American College of Occupational and Environmental Medicine (ACOEM) states careful advice regarding maximizing activities within the limits of symptoms is imperative once red flags have been ruled out. Any splinting or limitations placed on hand, wrist, and forearm activity should not interfere with total body activity in a major way. When treating with a splint in carpal tunnel syndrome, scientific evidence supports the efficacy of neutral wrist splints. Splinting should be used at night, and may be used during the day, depending upon activity. The patient has been diagnosed with carpal tunnel syndrome and, due to the patient's occupational duties, the former rigid velcro strap wrist braces were too difficult to use when attempting to deal with repetitive activity. Therefore, the physician is requesting a flexible wrist brace that will enable the patient to continue with her work without restricting her movements too rigorously. At this time, the requested service would be deemed appropriate for this patient in order for her to continue to improve with her functioning of normal activities of daily living, as well as her occupational

duties. The device meets guideline criteria for durable medical equipment. As such, the requested service is certified