

Case Number:	CM13-0030949		
Date Assigned:	12/04/2013	Date of Injury:	06/04/2013
Decision Date:	02/12/2014	UR Denial Date:	09/11/2013
Priority:	Standard	Application Received:	10/02/2013

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 Physical Medicine and Rehabilitation and is licensed to practice in California. 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 24-year-old male who reported an injury on 06/04/2013 after a large object crushed his right hand and ring finger. The patient was conservatively treated with physical therapy. The patient's most recent clinical examination findings included decreased range of motion of the right wrist described as 50 degrees in flexion, 50 degrees in extension, 20 degrees in ulnar deviation and 10 degrees in radial deviation with a negative Tinel's sign, Phalen's test and Finkelstein's test. The patient's right hand's physical appearance was described as scaly skin on the palmar aspect and nail avulsion with deformity of the right ring finger. Tenderness to palpation of the right hand was also noted. The patient had significantly decreased grip strength. The patient's diagnoses included posttraumatic right hand and shoulder syndrome with posttraumatic stiffness, status post crush injury of the right wrist and hand and right hand and finger tendinosis with nail avulsion. The patient's treatment plan included medications, bracing, an interferential unit, a hot/cold therapy unit, an MRI and physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the right wrist without contrast: Upheld

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 Page(s): 272.

Decision rationale: The requested MRI of the right wrist without contrast is not medically necessary or appropriate. [REDACTED] recommends an MRI as an option prior to evaluation by a qualified specialist. The clinical documentation submitted for review does not provide any evidence that the patient will be evaluated by a specialist. Additionally, it was noted within the documentation that the patient underwent x-rays. The results of those x-rays were not provided. Additionally, it was noted that the patient had participated in physical therapy. However, the efficacy of this therapy was not clearly indicated in the documentation. As the documentation does not clearly identify whether the patient has failed to respond to an adequate course of conservative therapy, and no red flag conditions were identified to support the need for an MRI; this imaging study would not be indicated. As such, the requested MRI of the right wrist without contrast is not medically necessary or appropriate.

Interferential Unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS), Page(s): 118.

Decision rationale: The requested interferential unit is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends an interferential unit for patients that have pain that is ineffectively controlled by medications, significant pain from surgical interventions and pain that has been unresponsive to conservative measures. The clinical documentation submitted for review does not provide any evidence that the patient has received an adequate course of conservative treatment that has failed to resolve the patient's pain. Additionally, there was no documentation that the patient had failed to respond to medication therapy. The California Medical Treatment Utilization Schedule also recommends the purchase of an interferential unit to be based on a 1 month clinical trial to support the efficacy of this treatment modality. There was no documentation that the patient had undergone an adequate trial to support the need for the purchase of this type of equipment. As such, the requested interferential unit is not medically necessary or appropriate.

Hot/cold Unit: Upheld

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 Page(s): 271.

Decision rationale: The requested hot/cold therapy unit is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine recommends at home applications of heat or cold packs before or after exercises are considered an option for acute hand, wrist and forearm disorders. The clinical documentation submitted for review does not provide any evidence that the patient has failed to respond to these types of treatments. There were no exceptional factors noted within the documentation to support the purchase of a hot/cold therapy unit as these are not supported for this type of injury. As such, the requested hot/cold unit is not medically necessary or appropriate.

Tramadol 50mg: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74.

Decision rationale: The requested Tramadol 50 mg prescribed 07/18/2013 was not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has pain that would benefit from medication management. The California Medical Treatment Utilization Schedule does not recommend the use of opioids as a first-line therapy. There is no documentation that the patient's pain has failed to respond to over-the-counter or first-line medications. As such, the continued use of Tramadol would not be supported. Therefore, Tramadol 50 mg prescribed 07/18/2013 is not medically necessary or appropriate.

Fluriflex prescribed 7/18/2013: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

Decision rationale: The requested Fluriflex prescribed on 07/18/2013 is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has pain that would benefit from medication management. However, the California Medical Treatment Utilization Schedule does not recommend topical analgesics as a first-line option. The clinical documentation submitted for review does not provide any evidence that the patient has failed to respond to first-line medications, such as antidepressants or anti-epileptics. Therefore, the use of this topical agent would not be supported. As such, the requested Fluriflex prescribed on 07/18/2013 is not medically necessary or appropriate.

Physical Therapy 3 times a week for 4 weeks for right wrist and hand: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: The requested physical therapy 3 times a week for 4 weeks for the right wrist/hand is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has undergone a trial of physical therapy. However, the efficacy of that therapy was not clearly established within the documentation. The California Medical Treatment Utilization Schedule recommends that continued physical therapy be based on objective functional improvements. As there was no documentation of objective functional improvements, continuation of therapy would not be supported. As such, the requested physical therapy 3 times a week for 4 weeks for the right wrist/hand is not medically necessary or appropriate.