

Case Number:	CM13-0036095		
Date Assigned:	12/13/2013	Date of Injury:	03/07/2012
Decision Date:	02/25/2014	UR Denial Date:	10/01/2013
Priority:	Standard	Application Received:	10/18/2013

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 Sports Medicine and is licensed to practice in Texas and New York. 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 40-year-old female who reported an injury on 03/07/2012 due to cumulative trauma which reportedly caused injury to the bilateral wrist. The patient was treated conservatively with physical therapy and splinting as well as corticosteroid injections that failed to resolve the patient's symptoms. The patient ultimately underwent right carpal tunnel release and trigger thumb release in 06/2013. The patient's most recent clinical examination findings included a positive Phalen's sign of the left hand with tenderness to palpation of the palmar aspect and good flexibility of the left fingers. The patient's diagnoses included left carpal tunnel syndrome and left trigger thumb and right wrist pain. The patient's treatment plan included activity modifications in the work environments, continuation of conservative treatment and a possible future left carpal tunnel release.

IMR ISSUES, DECISIONS AND RATIONALES

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

Scar silicone tape (1 box): Upheld

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

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

Decision rationale: The requested scar silicone tape (1 box) is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not recommend passive therapies as a standalone treatment. The clinical documentation submitted for review does not provide any evidence that the patient is participating in an active therapy program. There is no documentation that the patient is participating in a home exercise program or skilled supervised physical therapy. Therefore, the requested passive treatment would not be supported by guideline recommendations. As such, the requested scar silicone tape (1 box) is not medically necessary or appropriate.

Home paraffin 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 (ODG);

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

Decision rationale: The requested home paraffin unit is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not recommend passive therapies as a standalone treatment. The clinical documentation submitted for review does not provide any evidence that the patient is participating in an active therapy program. There is no documentation that the patient is participating in a home exercise program or skilled supervised physical therapy. Therefore, the requested passive treatment would not be supported by guideline recommendations. As such, the requested home paraffin unit is not medically necessary or appropriate.

A 15lb hand gripper: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine and Exercise Page(s): 98-99, 47.

Decision rationale: The requested 15 pound hand gripper is not medically necessary or appropriate. The clinical documentation submitted for review does not provide any evidence that the patient is participating in a home exercise program that would benefit from exercise equipment. The California Medical Treatment Utilization Schedule does recommend the use of exercise as part of a patient's treatment plan. However, there is no indication that the patient has failed to respond to self managed exercise and would benefit from the addition of exercise equipment. As such, the requested 15 pound hand gripper is not medically necessary or appropriate at this time.

Therapy putty: Upheld

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

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

Decision rationale: The requested therapy putty is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not recommend passive therapies as a standalone treatment. The clinical documentation submitted for review does not provide any evidence that the patient is participating in an active therapy program. There is no documentation that the patient is participating in a home exercise program or skilled supervised physical therapy. Therefore, the requested passive treatment would not be supported by guideline recommendations. As such, the requested therapy putty is not medically necessary or appropriate.

Heat massager by WAHL: Upheld

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

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

Decision rationale: The requested home heat massager by WAHL is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not recommend passive therapies as a standalone treatment. The clinical documentation submitted for review does not provide any evidence that the patient is participating in an active therapy program. There is no documentation that the patient is participating in a home exercise program or skilled supervised physical therapy. Therefore, the requested passive treatment would not be supported by guideline recommendations. As such, the requested heat massager by WAHL not medically necessary or appropriate.