

Case Number:	CM14-0100559		
Date Assigned:	07/30/2014	Date of Injury:	08/12/2012
Decision Date:	09/19/2014	UR Denial Date:	06/13/2014
Priority:	Standard	Application Received:	06/30/2014

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 Occupational Medicine 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 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:

Injured worker is a male with date of injury 8/12/2012. Per letter to claims adjuster dated 5/19/2014, the injured worker was seen for repeat evaluation. He is being treated for ulnar sided wrist pain. He reports gradual improvement in his symptoms. Therapy report reveals that the injured worker has made significant but incomplete improvement with a recommendation for an additional 12 sessions of therapy focusing on strengthening. On examination he continues to have tenderness over the ulnocarpal joint with positive ulnocarpal grind. Diagnosis is status post submuscular ulnar nerve transposition.

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional hand therapy x12: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 130.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine section Page(s): 98-99, Postsurgical Treatment Guidelines Page(s): 18, 22.

Decision rationale: The claims administrator reports that the injured worker has had 48 visits of occupational therapy to date. The post-surgical guidelines recommend 20 visits over 10 weeks of post-surgical treatment, and the postsurgical physical medicine treatment period is 6 months.

Physical therapy focused on active therapy to restore flexibility, strength, endurance, function, range of motion and alleviate discomfort is supported by the cited guideline. This injured worker may need physical therapy, but the request should be accompanied by previous participation and efficacy of physical therapy. The Chronic Pain Medical Treatment Guidelines support physical therapy that is providing a documented benefit. Physical therapy should be provided at a decreasing frequency as the guided therapy becomes replaced by a self-directed home exercise program. The Chronic Pain Medical Treatment Guidelines recommend 8-10 visits over 4 weeks for neuralgia, neuritis and radiculitis, unspecified. The injured worker has had extensive amount of therapy, in excess of the recommendations for postsurgical therapy and chronic pain combined. The injured worker should be prepared to continue with a home exercise program without the assistance of a therapist. The request for Additional hand therapy x12 is determined to not be medically necessary.

Functional capacity evaluation: 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 ACOEM Chapter 2 General Approach to Initial Assessment and Documentation Page(s): 21. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Guidelines for Performing an FCE.

Decision rationale: The MTUS Guidelines recommend considering a functional capacity evaluation when necessary to translate medical impairment into functional limitations and determine work capability. The ODG provide criteria for when a functional capacity evaluation may be utilized. These criteria include repeated difficulty with returning to work, or when the injured worker is at or near reaching maximum medical improvement. The requesting physician is requesting additional therapy, not suggesting that the injured worker is at maximum medical improvement. The requesting physician reports that a trial of return to work is desired, but he has lost his job, so a functional capacity evaluation is desired to determine ability to work. A functional capacity evaluation is not necessary just because the employee is currently not working. Medical necessity of this request has not been established. The request for Functional capacity evaluation is determined to not be medically necessary.