

Case Number:	CM14-0111301		
Date Assigned:	08/01/2014	Date of Injury:	07/29/2013
Decision Date:	09/09/2014	UR Denial Date:	07/15/2014
Priority:	Standard	Application Received:	07/16/2014

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 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:

The patient is a 45-year-old female who has submitted a claim for right Dequervain's tenosynovitis, right lateral epicondylitis, right flexor tenosynovitis, right wrist OA, and right triangular fibrocartilage complex (TFCC) tear associated with an industrial injury date of 07/29/2013. Medical records from 07/29/2013 to 07/15/2014 were reviewed and showed that patient complained of right medial wrist pain graded 5/10 with associated numbness. The pain was aggravated with right hand gripping and relieved with rest. Physical examination of the right wrist revealed tenderness upon palpation over the right medial wrist. Decreased wrist range of motion (ROM) in all planes was noted. Right wrist grip strength was decreased. MRI of the wrist dated 02/26/2014 revealed radioscaphoid and scapholunate osteoarthritis, flexor tenosynovitis, and TFCC tear. EMG/NCV study of the upper extremities dated 05/01/2014 revealed right carpal tunnel syndrome with moderate severity without evidence of ulnar neuropathy. Treatment to date has included right subfascial injection of the right wrist and finger flexors on 03/28/2014, TFCC injection on 05/27/2014, physical therapy, and pain medications. Utilization review dated 07/15/2014 denied the request for 6 physical therapy sessions for the right hand/wrist because there was no indication that the patient could not be independent in home exercise program (HEP) at this point.

IMR ISSUES, DECISIONS AND RATIONALES

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

6 Physical Therapy sessions for the right hand / wrist: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical therapy.

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

Decision rationale: The CA MTUS Chronic Pain Medical Treatment Guidelines, active therapy is recommended for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Physical medicine guidelines allow for fading of treatment frequency from up to 3 visits per week to 1 or less plus active self-directed home physical medicine. In this case, the patient completed 17 visits of physical therapy from 05/05/2014 - 7/15/2014 with no documentation of treatment failure. There is no documentation as to why the patient cannot self-transition to HEP. The medical necessity for additional physical therapy has not been established. Therefore, the physical therapy, 6 sessions for the right hand / wrist is not medically necessary and appropriate.