

Case Number:	CM14-0158644		
Date Assigned:	10/02/2014	Date of Injury:	12/08/2013
Decision Date:	12/10/2014	UR Denial Date:	09/11/2014
Priority:	Standard	Application Received:	09/26/2014

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 Physical Medicine and Rehabilitation 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 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:

Medical Records reflect the claimant is a 27 year old male who sustained a work injury on 12-8-13. Office visit on 4-15-14 the claimant was having right wrist pain and pain on the right thumb. One examination, the claimant had TTP and right wrist pain with wrist extension. Office visit on 8-26-14 notes the request for physical therapy 2-3 x 6 weeks, right wrist splint, Ibuprofen, EMG/NCS of the upper extremity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 2-3 x 6 to right wrist: 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 physical medicine Page(s): 98-99.

Decision rationale: Chronic Pain Medical Treatment Guidelines notes that one should allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. There is an absence in documentation noting that this claimant cannot perform a home exercise program. There are no extenuating circumstances to support physical

therapy at this juncture. There is no indication of his response to prior physical therapy. Therefore, the medical necessity of this request is not established.

Refill medication: Ibuprofen 800mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67-73. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter- NSAIDS

Decision rationale: Chronic Pain Medical Treatment Guidelines as well as ODG reflect that NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. There is an absence in documentation documenting medical necessity for the long term use of an NSAID. There is no documentation of functional improvement with this medication. Therefore, the medical necessity of this request is not established.