

Case Number:	CM14-0025436		
Date Assigned:	06/11/2014	Date of Injury:	10/01/2010
Decision Date:	07/18/2014	UR Denial Date:	02/14/2014
Priority:	Standard	Application Received:	02/27/2014

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 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 injured worker is a 43-year-old male who reported an injury on 10/01/2010. The mechanism of injury was not provided. The clinical note dated 01/23/2013 noted the injured worker had pain of the left elbow, left wrist, and left shoulder blade. Upon exam, there was tenderness over the lateral epicondyle, and pain with resistance against wrist and finger extension with synovial thickening. The elbow range of motion values were full extension with pain and substitutional patterns, 40/40 degrees of supination/pronation, 40/10 degrees of wrist extension/flexion, and 10/20 degrees of radial deviation/ulnar deviation. Prior treatment included physical therapy and surgery. The diagnoses were sprain/strain of the elbow and forearm, bursitis, synovitis, tenosynovitis wrist, other joint derangement not elsewhere classified. The provider recommended occupational therapy 2 times a week for 4 weeks for the left wrist and left elbow. The provider's rationale was not provided. The request for authorization form was not included in the medical documents for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

OT TWO TIMES FOUR WEEKS FOR LEFT WRIST AND LEFT ELBOW: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99, Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation ACOEM Pain, Suffering, and the Restoration of Function Chapter (page 114).

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

Decision rationale: The MTUS Chronic Pain Guidelines state that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific task or exercise. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. The MTUS Chronic Pain Guidelines recommend up to 10 visits of therapy over 4 weeks. The injured worker has had at least 6 physical therapy visits for the left wrist and left elbow. There is a lack of documentation regarding prior therapy to verify if functional improvements were made. In addition, the request for 8 additional occupational therapy visits exceeds the Guideline recommendations. As such, the request is not medically necessary and appropriate.