

Case Number:	CM14-0039250		
Date Assigned:	06/27/2014	Date of Injury:	12/08/2013
Decision Date:	09/12/2014	UR Denial Date:	03/10/2014
Priority:	Standard	Application Received:	04/03/2014

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 Pain Medicine 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:

The injured worker is a 27 year old male who reported an injury to his right wrist. A clinical note dated 12/09/13 indicated the patient sustaining crush type injury at the right wrist. The hand demonstrated no significant symptoms. The injured worker stated the wrist got caught crushed in a conveyor belt. Swelling was identified at the right wrist and hand with superficial abrasion at the volar aspect of the wrist. The injured worker utilized hydrocodone and tramadol for pain relief. A clinical note dated same note indicated the patient demonstrating range of motion deficits at the right wrist. The injured worker rated the pain 10/10. Movements in all planes exacerbated the pain. A clinical note dated 12/11/13 indicated the patient utilizing cold packs at the affected area. The abrasions presented as clean without any visible foreign bodies or signs of infection. Tenderness was decreased throughout the right wrist. Tenderness to palpation was minimal at the dorsal aspect. A clinical note dated 01/03/14 indicated the patient reporting paresthesia at the right hand along with decreased range of motion. Upon exam, the injured worker demonstrated 60 degrees of right wrist flexion, 20 degrees of ulnar deviation with 3/5 strength with both flexion/extension. The patient had positive Tinel sign. The utilization review dated 03/06/14 resulted in a denial for electrodiagnostic studies as no information was submitted confirming completion of any conservative treatment addressing the right upper extremity complaints.

IMR ISSUES, DECISIONS AND RATIONALES

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

Occupational therapy 3 times a week for 6 weeks on the right wrist: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist and Hand Chapter, Physical/ Occupational therapy.

Decision rationale: The injured worker sustained a crush type injury at the right wrist. A total of 10 sessions of physical therapy are indicated for an injury of this nature. The request for a total of 18 occupational therapy sessions exceeds guideline recommendations as no exceptional factors were identified in the clinical documentation. No information was submitted regarding previous utilization of conservative treatment. It is unclear as to the number of sessions the injured worker has completed to date. Given that no information was submitted regarding previous involvement with therapeutic interventions or response to treatments this request is not indicated as medically necessary.

EMG on the right upper extremities: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Electrodiagnostic testing, Electromyography and Nerve Conduction Studies.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

Decision rationale: The injured worker underwent conservative treatment addressing right upper extremity complaints. However, no information was submitted regarding completion of all conservative treatment as no therapy notes were submitted for review. The patient no information was submitted regarding neurological deficits at the right upper extremity. Therefore, it is unclear how the patient will benefit from electrodiagnostic studies.

NCV on the right upper extremities: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Electrodiagnostic testing, Electromyography and Nerve Conduction Studies.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

Decision rationale: The injured worker underwent conservative treatment addressing right upper extremity complaints. However, no information was submitted regarding completion of all conservative treatment as no therapy notes were submitted for review. The injured worker no information was submitted regarding neurological deficits at the right upper extremity. Therefore, it is unclear how the injured worker will benefit from electrodiagnostic studies.

