

Case Number:	CM14-0050333		
Date Assigned:	06/25/2014	Date of Injury:	09/12/2011
Decision Date:	10/09/2014	UR Denial Date:	03/04/2014
Priority:	Standard	Application Received:	03/24/2014

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 Illinois. 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 36 year old male who reported injury on 10/07/2011. The mechanism of injury was not provided. Diagnoses included left radial tunnel syndrome. The past treatments were not included. The progress note dated 02/20/2014 noted the injured worker complained of increasing tingling along the radial aspect of his distal fore arm. The physical exam revealed the injured worker to be almost 6 weeks post-operative, with normal wrist and elbow motion, a positive Tinel's sign over the superficial radial nerve, and good active wrist and finger extension. Medications were not included. The treatment plan stated the injured worker would start a strengthening program. The Request for Authorization form was not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Occupational Therapy 3xwk x 4 wks Left Wrist/Elbow: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

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

Decision rationale: The request for occupational therapy 3x wk x4 wks left wrist and elbow is not medically necessary. The injured worker had left radial tunnel syndrome, with unspecified surgery, with normal wrist and elbow motion, a positive Tinel's sign over the superficial radial

nerve, and good active wrist and finger extension. The California MTUS guidelines recommend physical medicine (occupational or physical therapy) to restore flexibility, strength, endurance, function, and range of motion. The guidelines also outline treatment for 9-10 visits over 8 weeks, and to continue active therapies at home as an extension of the treatment process. There is no indication of functional deficits or pain. The request for 12 sessions of occupational therapy exceeds the guideline recommendations. There is a gap in documentation from February 2014 through the present. There is no documentation of the injured worker's current condition to whether the injured worker has significant objective functional deficits and determine medical necessity. Additionally, there is a lack of documentation indicating the injured worker had therapy previously, as well as the efficacy of any prior therapy. Given the previous, 12 sessions of occupational therapy is excessive, and not indicated at this time. Therefore, the request is not medically necessary.