

Case Number:	CM14-0077855		
Date Assigned:	07/18/2014	Date of Injury:	08/29/2013
Decision Date:	09/22/2014	UR Denial Date:	04/28/2014
Priority:	Standard	Application Received:	05/28/2014

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, Rehabilitation and Pain Medicine and is licensed to practice in Texas and Ohio. 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 48-year-old female who reported an injury on 08/29/2013. The mechanism of injury was reported when the injured worker was pulling a rack of clothes and it tipped over. The previous treatments include occupational therapy. Diagnostic testing includes EMG/NCV. Within the clinical note dated 03/31/2014, it was reported the injured worker complained of right hand/wrist pain with radiation to the right shoulder. She described the pain as sharp pain. Upon the physical examination, the provider noted the injured worker rated her pain 8/10 in severity. The provider noted the injured worker had full range of motion of the right wrist upon examination. The provider noted no tenderness over the right wrist. The provider noted sensation was intact to light touch and pinprick in all dermatomes of the right upper extremity for wrist. The injured worker had a negative Phalen's test for the left median nerve. The injured worker had a positive Phalen's for the right median nerve compression and a positive Tinel's of the right median nerve compression. The provider requested postoperative occupational therapy 2 times a week for 4 weeks for the right wrist. However, a rationale was not provided for clinical. The Request for Authorization was not provided for clinical review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post operative Occupational Therapy 2 x wk x 4 wks right wrist: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines
Page(s): 16.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 16.

Decision rationale: The request for postoperative occupational therapy 2 times a week for 4 weeks for the right wrist is not medically necessary. The Postsurgical Treatment Guidelines note there is limited evidence demonstrating the effectiveness of physical therapy or occupational therapy for carpal tunnel syndrome. The evidence may justify 3 to 5 visits over 4 weeks after surgery, up to a maximum shown below. The guidelines note postsurgical treatment of 3 to 8 visits over 3 to 5 weeks, with postsurgical physical medicine treatment of 3 months. There is lack of documentation indicating the efficacy of the prior course of occupational therapy the injured worker had previously undergone. The number of sessions the injured worker previously had undergone was not provided for clinical review. The sessions requested exceeds the guidelines recommendations with an unknown number of previous sessions the injured worker has undergone. Therefore, the request is not medically necessary.