

Case Number:	CM14-0096859		
Date Assigned:	07/23/2014	Date of Injury:	04/01/2009
Decision Date:	08/28/2014	UR Denial Date:	06/03/2014
Priority:	Standard	Application Received:	06/11/2014

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 Anesthesiology, has a subspecialty in 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 40 year old female who sustained an injury on 04/01/09. No specific mechanism of injury was noted. The injured worker was seen on 05/12/14 with complaints of pain in the right hand. The report is difficult to interpret due to handwriting and copy quality. Physical examination noted a possible positive Tinel's and Phalen's sign. There was no indication of any significant loss of range of motion or evidence of instability. The injured worker was recommended for further physical therapy at this evaluation. The injured worker was also recommended for an interferential unit. The requested physical therapy two times a week for four weeks, quantity 8, Norco 2.5/325mg, quantity 60, Voltaren XR 100mg, quantity 30, OS4 interferential stimulator, and a right wrist thumb brace was denied by utilization review on 06/03/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy two times a week for four weeks (Qty. 8): 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: In regards to the request for physical therapy twice a week for four weeks, this reviewer would not have recommended this request as medically necessary. The clinical documentation submitted for review did note continuing right wrist pain as well as pain in the hand. There did appear to be positive Tinel's and Phalen's signs with tenderness to palpation. There was no significant loss of range of motion or any evidence of instability in the right wrist or hand. No specific goals were identified in the clinical reports for the requested physical therapy. It is unclear what the injured worker's prior conservative treatment has been to date including past physical therapy. Also, guidelines do not recommend more than an initial six sessions of physical therapy to determine efficacy and functional improvements obtained with this modality. As such, the requested eight sessions of physical therapy would not be indicated as medically appropriate at this point in time.

Norco 2.5/325mg #60: 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 Opioids, Criteria for Use Page(s): 88-89.

Decision rationale: In regards to the request for Norco 2.5/325mg, quantity 60, this reviewer would not have recommended this request as medically necessary. In review of the one clinical note provided for review there is no clear documentation regarding the efficacy of this medication. No specific rationale for Norco was provided for review. Given the limited rationale provided regarding the continued use of this medication, this reviewer would not recommend the request as medically necessary.

Voltaren XR 100mg #30: 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 NSAIDs Page(s): 67-68.

Decision rationale: In regards to the use of Voltaren XR 100mg quantity 30, this reviewer would not have recommended this medication as medically necessary based on the clinical documentation provided for review and current evidence based guideline recommendations. The chronic use of prescription non-steroidal anti-inflammatory medications (NSAIDs) is not recommended by current evidence based guidelines as there is limited evidence regarding their efficacy as compared to standard over-the-counter medications for pain such as Tylenol. Per guidelines, NSAIDs can be considered for the treatment of acute musculoskeletal pain secondary to injury or flare ups of chronic pain. There is no indication that the use of NSAIDs in this case was for recent exacerbations of the claimant's known chronic pain. The request is not medically necessary.

OS4/Interferential Stimulator: 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 Transcutaneous Electrotherapy Page(s): 114-121.

Decision rationale: In regards to the request for an OS4 interferential stimulator, this request would not have been supported as medically necessary. The use of interferential stimulation can be considered as an option per guidelines. This should be performed in conjunction with a formal plan for rehabilitation such as active physical therapy. To date, there is no indication that the injured worker has utilized an interferential stimulator on a trial basis with documented functional improvement that would support purchasing this type of unit. Therefore, this reviewer would not have recommended this request as medically necessary.

Right Wrist/Thumb Brace: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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 & Hand, Splinting.

Decision rationale: In regards to the request for a right wrist and thumb brace, this reviewer would not have recommended this request as medically necessary based on review of the clinical documentation submitted as well as current evidence based guidelines. There is no documentation regarding any significant instability of the right wrist or hand that would have required bracing. No acute injuries were documented in the clinical reports. Therefore, this reviewer would not have recommended this request as medically necessary.