

Case Number:	CM14-0194392		
Date Assigned:	12/02/2014	Date of Injury:	04/09/2012
Decision Date:	01/29/2015	UR Denial Date:	10/21/2014
Priority:	Standard	Application Received:	11/20/2014

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 Rehab 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 underlying date of injury in this case is 04/09/2012. The date of the utilization review under appeal is 10/21/2014. On 09/29/2014, the patient was seen in initial physician evaluation. That physician reviewed this patient's history of an injury when the patient was bending over to check on a machine, and the machine turned on and severely cut the patient's right fifth, fourth, and middle fingers. The patient underwent surgery to reattach his fingers. The patient had subsequently participated in various sessions of conservative therapy until the clinic closed down and he could not continue the treatment. The patient reported ongoing pain in both wrists and hands as well as the left elbow and both shoulders. Bilateral wrist maximum strength was 45 pounds. The patient had 3+ spasm and tenderness at bilateral anterior wrists, posterior extensor tendons, and thenar eminences. The recommended treatment plan included additional physical therapy to continue with functional improvement as well as electrodiagnostic testing because of complaints of numbness in both hands and a positive Phalen's test and also a multi-stim unit due to other treatments having been attempted with continued pain for over 3 months. Functional improvement measures also recommended through a functional capacity evaluation, with the treating physician noting that it was important to have an assessment that can be used repeatedly over the course of treatment. Work hardening screening was also planned to determine if the patient were a candidate for a work hardening program.

IMR ISSUES, DECISIONS AND RATIONALES

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

Work conditioning/Hardening Screening: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 125.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Work Hardening Page(s): 125.

Decision rationale: The California Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines discuss work hardening on page 125; it is indicated when the patient has a work-related condition with functional limitations precluding ability to safely achieve current job demands at the medium or higher demand level. There is no specific discussion about difficulties returning to work or what particular type of work the patient would return to or why the patient would require work conditioning, rather than traditional physical therapy, to achieve a return to work. Therefore, the medical records do not support an indication for the requested work hardening screening. This request is not medically necessary.

Qualified Functional Capacity Evaluation, quantity 1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Functional Capacity Evaluation (FCE)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Work Conditioning/Work Hardening Page(s): 125.

Decision rationale: The California Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines discuss functional capacity evaluations in the context of work conditioning/work hardening, page 125; a functional capacity evaluation may be required to show consistent results with maximal effort and demonstrate capacities below an employer-verified physical demands analysis. The medical records do not include a discussion of a plan to return to work or a rationale as to why there is concern about the patient's ability to return to his former job. The medical record discusses periodic functional assessments which refer to part of a physician office visit but do not refer to a formal functional capacity evaluation. For these reasons this request is not supported by the treatment guidelines. This request is not medically necessary.

Multi-Interferential Stimulator, 1 month rental: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular Electrical Stimulation, Interferential Stimulation Page(s): 121, 118.

Decision rationale: The medical record indicates that this request is for a multimodality electrical stimulator. Such a stimulator would include neuromuscular electrical stimulation. The

California Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines, section on neuromuscular electrical stimulation, page 121, states that neuromuscular electrical stimulation is not recommended for chronic pain but is only recommended for post-stroke rehabilitation. Additionally, interferential stimulation is discussed in the Medical Treatment Utilization Schedule beginning on page 118. This treatment is recommended only as a second-line treatment when first-line physical medicine treatment options have failed. The patient has not met these criteria. Thus, overall the patient does not meet the requirements for the requested multi-stimulator unit. This request is not medically necessary.