

Case Number:	CM15-0005952		
Date Assigned:	01/20/2015	Date of Injury:	04/12/2012
Decision Date:	03/19/2015	UR Denial Date:	12/08/2014
Priority:	Standard	Application Received:	01/12/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 42 year old male with a date of injury as 04/19/2012. The current diagnoses include dorsal intercalated segment/instability, left wrist pain, and left wrist sprain/strain. Previous treatments include medications and physical therapy. Primary treating physician's reports dated 07/18/2014 through 11/07/2014, formal pain consultation dated 07/18/2014, physical therapy progress notes, urine drug screening report, and diagnostic testing results were included in the documentation submitted for review. Report dated 11/07/2014 noted that the injured worker presented with complaints that included left wrist pain, rated 6 out of 10 on the pain scale, and described as sharp, stabbing left wrist pain with numbness and radiation to the pinky, and pain is increased with activity. Physical examination revealed grip strength testing causes pain in the left wrist, range of motion elicits pain, and tenderness to palpation in the in the left wrist, and Tinel's sign is positive. Treatment plan included a request for occupational therapy to increase activities of daily living and increase range of motion and manage pain. The injured worker is not working. The utilization review performed on 12/08/2014 non-certified a prescription for occupational therapy 2 x per week for 4 weeks for the left wrist based on no documentation was provided to indicate if the request was for initial treatment with occupational therapy. The reviewer referenced the California MTUS and Official Disability Guidelines in making this decision.

IMR ISSUES, DECISIONS AND RATIONALES

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

Occupational therapy 2 x 4 for the left wrist: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Forearm, Wrist, & Hand (Acute & Chronic) Chapter, under Physical/ Occupational therapy

Decision rationale: Based on the 10/10/14 progress report provided by treating physician, the patient presents with left wrist pain. The request is for OCCUPATIONAL THERAPY 2X4 FOR THE LEFT WRIST. Patient's diagnosis on 10/10/14 included left wrist sprain/strain and dorsal intercalated segment instability. Treater is requesting occupational therapy to "increase ADLs and increase ROM and manage pain." Physical therapy note dated 07/23/14 showed 9 visits from 07/23/14 to 08/20/14. The patient is not working and remains temporarily totally disabled. ODG-TWC, Forearm, Wrist, & Hand (Acute & Chronic) Chapter, under Physical/ Occupational therapy states: "ODG Physical/Occupational Therapy Guidelines Allow for fading of treatment frequency (from up to 3 visits or more per week to 1 or less), plus active self-directed home PT. More visits may be necessary when grip strength is a problem, even if range of motion is improved. Sprains and strains of wrist and hand (ICD9 842): 9 visits over 8 weeks." Treater has not provided reason for the request. Given patient's diagnosis, a short course of physical therapy would be indicated. However, physical therapy note dated 07/23/14 showed 9 visits from 07/23/14 to 08/20/14. There is no documentation of functional improvement provided from prior sessions, nor discussion of significant change in symptoms to warrant additional physical therapy. Treater does not discuss any flare-ups, explain why on-going therapy is needed, or reason the patient is unable to transition into a home exercise program. Therefore, the request IS NOT medically necessary.