MAXIMUS Federal Services

Case Number:	CM15-0006687		
Date Assigned:	01/26/2015	Date of Injury:	12/08/2009
Decision Date:	03/24/2015	UR Denial Date:	12/31/2014
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, Arizona
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 50-year-old female who reported an injury on 12/08/2009. The injured worker had a thumb metacarpophalangeal joint ulnar collateral ligament repair. The diagnoses included right wrist TFCC tear with distal radioulnar destruction and internal derangement and wrist stiffness. The mechanism of injury was not provided. The injured worker underwent electrodiagnostic studies on 08/12/2013. The documentation of 11/03/2014 revealed the injured worker had a grossly prominent ulnar head with gross laxity of the DRUJ. The wrist range of motion was full supination and pronation. The wrist extension was approximately 45 degrees and flexion was 35 degrees. The ulnar snuffbox was mildly tender with positive piano keying. The request was made for additional occupational therapy for range of motion exercises, 2 treatments for the next 4 weeks in addition to what the injured worker was authorized for. Additionally, the recommendation was for a possible surgical fixation when the injured worker had gained near full range of motion and strengthening. The mechanism of injury was noted to be a fall. Prior therapies included physical therapy. There was a lack of Request for Authorization submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional Occupational therapy x 8: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guideline (ODG)-TWC Forearm, Wrist, & Hand Procedure

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

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend physical medicine treatment for up to 10 visits for myalgia and myositis. The clinical documentation submitted for review indicated the injured worker was currently under therapy treatment. There was a lack of documentation of objective functional benefit and remaining objective functional deficits. Additionally, the request as submitted failed to indicate the body part to be treated with occupational therapy. There was a lack of documentation of the quantity of prior sessions attended. Given the above and the lack of documentation, the request for additional occupational therapy x8 is not medically necessary.