

Case Number:	CM15-0103821		
Date Assigned:	06/08/2015	Date of Injury:	08/12/2013
Decision Date:	07/07/2015	UR Denial Date:	05/08/2015
Priority:	Standard	Application Received:	05/29/2015

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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive Medicine

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 45 year old female with an August 12, 2013 date of injury. A progress note dated April 21, 2015 documents subjective findings (pain is improving with therapy), objective findings (mild trapezial and paracervical tenderness on the right; mild lateral epicondylar and dorsal forearm tenderness in the right; mild swelling and slight stiffness in the right index metacarpophalangeal joint; pain with range of motion at the right index metacarpophalangeal joint), and current diagnoses (status post laceration to the dorsal aspect of the right index metacarpophalangeal joint; status post incision and drainage of the right index metacarpophalangeal joint with synovectomy; right forearm tendinitis; trapezial and paracervical strain). Treatments to date have included occupational therapy, magnetic resonance imaging of the right hand (June 18, 2014; showed large second metacarpophalangeal joint effusion/synovitis, volar subluxation of the metacarpal without frank dislocation or fracture, and diffuse capsular laxity, particularly on the palmar capsule proximally), medications, and work restrictions. The treating physician documented a plan of care that included occupational therapy for the right hand.

IMR ISSUES, DECISIONS AND RATIONALES

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

Occupational therapy 2 times a week for 6 weeks to the right hand: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation Page(s): 260-278, Chronic Pain Treatment Guidelines Occupational Therapy and Physical Medicine Page(s): 74, 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, & Hand, Physical/Occupational therapy.

Decision rationale: MTUS and ODG state regarding wrist occupational therapy, "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." ODG states "Recommended. Positive (limited evidence). See also specific physical therapy modalities by name. Also used after surgery and amputation. Early physical therapy, without immobilization, may be sufficient for some types of undisplaced fractures. It is unclear whether operative intervention, even for specific fracture types, will produce consistently better long-term outcomes. There was some evidence that 'immediate' physical therapy, without routine immobilization, compared with that delayed until after three weeks immobilization resulted in less pain and both faster and potentially better recovery in patients with undisplaced two-part fractures. Similarly, there was evidence that mobilization at one week instead of three weeks alleviated pain in the short term without compromising long-term outcome. (Handoll-Cochrane, 2003) (Handoll2-Cochrane, 2003) During immobilization, there was weak evidence of improved hand function in the short-term, but not in the longer term, for early occupational therapy, and of a lack of differences in outcome between supervised and unsupervised exercises. Post-immobilization, there was weak evidence of a lack of clinically significant differences in outcome in patients receiving formal rehabilitation therapy, passive mobilization or whirlpool immersion compared with no intervention. There was weak evidence of a short-term benefit of continuous passive motion (post external fixation), intermittent pneumatic compression and ultrasound. There was weak evidence of better short-term hand function in patients given physical therapy than in those given instructions for home exercises by a surgeon. (Handoll-Cochrane, 2002) (Handoll-Cochrane, 2006) Hand function significantly improved in patients with rheumatoid arthritis after completion of a course of occupational therapy ($p < 0.05$). (Rapoliene, 2006) Active Treatment versus Passive Modalities: See the Low Back Chapter for more information. The use of active treatment modalities instead of passive treatments is associated with substantially better clinical outcomes. The most commonly used active treatment modality is Therapeutic exercises (97110), but other active therapies may be recommended as well, including Neuromuscular reeducation (97112), Manual therapy (97140), and Therapeutic activities/exercises (97530). Arthropathy, unspecified (ICD9 716.9): Post-surgical treatment, arthroplasty/fusion, wrist/finger: 24 visits over 8 weeks. Pain in joint (ICD9 719.4): 9 visits over 8 weeks." The medical documentation provided indicates this patient has had at least 20 previous session of OT. The treating physician has not provided documentation of objective functional improvement with previous therapy. Additionally, the requested number of treatments is in excess of guideline recommendations for chronic pain. As such, the request for Occupational therapy 2 times a week for 6 weeks to the right hand is not medically necessary.