

Case Number:	CM15-0105777		
Date Assigned:	06/10/2015	Date of Injury:	03/10/2003
Decision Date:	07/15/2015	UR Denial Date:	05/08/2015
Priority:	Standard	Application Received:	06/02/2015

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 52-year-old female, who sustained an industrial injury on 3/10/2003. Diagnoses have included severe osteoarthritis of radiolunate joint status post failed fusion right wrist. Treatment to date has included immobilization using a cast and/or brace and medication. According to the progress report dated 10/8/2014, exam of the right wrist revealed pain with even passive, limited motion. The physician recommendation was for total fusion of the right wrist. There were significant degenerative changes at the radiolunate and lunocapitate joints of the right wrist. Authorization was requested for post-op occupational therapy and home assistant.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post-operative occupational therapy 3 times a week for 4 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines, Forearm, Wrist & Hand.

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

Decision rationale: This patient presents with chronic pain in the right wrist. The request is for POST-OPERATIVE OCCUPATIONAL THERAPY 3x A WEEK FOR 4 WEEKS. There is no RFA provided and the date of injury is 03/10/03. The patient underwent fusion of the TMC joint and wrist, in 2010. In 2013, the patient underwent removal the screws in the right wrist. Per 10/08/14 report, physical examination of the right wrist revealed a well-healed dorsal scar with tenderness to palpation and limited range of motion. The diagnoses have included severe osteoarthritis of radiolunate joint status post failed fusion right wrist. The patient is permanent and stationary. The current request of physical therapy appears outside of post-surgical period as surgery was more than 6 months from the request date. For non-post-operative therapy treatments, MTUS guidelines page 98 and 99 allow 8-10 sessions for neuralgia, neuritis, and radiculitis, unspecified and 9-10 sessions for myalgia and myositis, unspecified. In this case, the most recent progress report provided is dated 10/08/14 and is prior to this request. The utilization review denial letter states that the request is from 5/1/15. There are no current reports discussions the request. The patient is clearly outside of the post-surgical period from wrist/thumb surgery from prior year. MTUS recommends up to 10 sessions for this myalgia/myositis/neuritis type of condition. The patient does not present with RSD for which more therapy is allowed. There is no discussion as to why the patient is unable to do the necessary home exercises. The request IS NOT medically necessary.

Home assistant for cooking and cleaning: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home health care. Decision based on Non-MTUS Citation Official Disability Guidelines, Forearm, Wrist & Hand.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home health service Page(s): 51.

Decision rationale: This patient presents with chronic pain in the right wrist. The request is for HOME ASSISTANT FOR COOKING AND CLEANING. There is no RFA provided and the date of injury is 03/10/03. The patient underwent fusion of the TMC joint and wrist, in 2010. In 2013, the patient underwent removal the screws in the right wrist. Per 10/08/14 report, physical examination of the right wrist revealed a well-healed dorsal scar with tenderness to palpation and limited range of motion. The diagnoses have included severe osteoarthritis of radiolunate joint status post failed fusion right wrist. The patient is permanent and stationary. MTUS Guidelines page 51 has the following regarding home service, "recommended only for otherwise recommended medical treatment for patients who are homebound on a part time or intermittent basis, generally up to no more than 35 hours per week. Medical treatment does not include homemaker services like shopping, cleaning, laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed." In this case, the most recent progress report provided is dated 10/08/14 and is prior to this request. The MTUS guidelines are clear that Home Care is for medical treatment only and for no more than 35 hours per week. MTUS states that medical treatment does not include homemaker services, such as cleaning and cooking. Additionally, the treater's current reports are not provided discussion the rationale for the request. The patient's wrist/thumb surgery for hardware removal

was from 2014 and there is hardly a need for home-care following hardware removal.
The request IS NOT medically necessary.