

Case Number:	CM15-0131076		
Date Assigned:	07/17/2015	Date of Injury:	08/01/2014
Decision Date:	08/31/2015	UR Denial Date:	06/24/2015
Priority:	Standard	Application Received:	07/07/2015

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: Pennsylvania, Ohio, 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 48 year old female patient who sustained an industrial injury on 08/01/2014. The accident was described as while working as an underwriter she experienced cumulative trauma with resulting injury over the course of employment. A follow up visit dated 12/31/2014 reported current treating diagnoses as: tendinitis of right wrist, and myofascial pain syndrome. The patient is with subjective complaint of having right hand/wrist pain. Treatment modality trialed to include: ergonomic updates to work environment, activity modification, diagnostic medical equipment utilization, occupational therapy referral; medications. She is with subjective complaint of right wrist hand and finger pains. The pain radiates from the wrist up the forearm and into the hand. She states completing a course of acupuncture and has one session of therapy remaining. The following diagnoses were applied: tendinitis of right wrist, and myofascial pain. She is instructed to complete final therapy session, continue with home exercise program, continue wearing brace utilize Voltaren gel and Nortriptyline noted increased to 20mg at nighttime. She is to remain on a modified work duty. A more recent primary visit dated 04/03/2015 reported treating diagnoses of: other tenosynovitis of hand and wrist, and lateral epicondylitis. There is recommendation for additional occupational therapy sessions.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post-op physical therapy 3 times per week for 4 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines
Page(s): 20.

Decision rationale: MTUS recommends 16 post-op PT visits status post TFCC reconstruction, with half of those as an initial prescription. The request for 12 visits thus exceeds this guideline for initial post-op therapy; there is no documented rationale for an exception to this guideline. The request is not medically necessary.

Associated surgical service: cold therapy unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 48.

Decision rationale: ACOEM recommends use of low-tech cold or hot packs in the acute phase of an injury or acute post-op periods. These guidelines recommend a cold therapy unit for some specific anatomical areas but not for the wrist/TFCC area. Thus a cold therapy unit is not recommended by the treatment guidelines in this post-op period. This request is not medically necessary.

Associated surgical service: Interferential (IF) unit with supplies: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Stimulation Page(s): 118-120.

Decision rationale: MTUS recommends interferential stimulation as an option in specific clinical situations after first-line treatment has failed. Examples of situations where MTUS supports interferential stimulation include where pain is ineffectively controlled due to diminished effectiveness of medication or medication side effects or history of substance abuse. The records do not document such a rationale or alternate rationale as to why interferential stimulation would be indicated rather than first-line treatment. Therefore this request is not medically necessary.