

Case Number:	CM15-0185697		
Date Assigned:	09/25/2015	Date of Injury:	09/18/2014
Decision Date:	11/03/2015	UR Denial Date:	08/20/2015
Priority:	Standard	Application Received:	09/21/2015

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, Indiana, New York
 Certification(s)/Specialty: Internal 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 52-year-old male with a date of injury of September 18, 2014. A review of the medical records indicates that the injured worker is undergoing treatment for history of a right distal radius fracture, right hand reflex sympathetic dystrophy and right radial ulnar synostosis. Medical records dated June 15, 2015 indicate that the injured worker complains of pain rated at a level of 6 to 7 out of 10 with associated weakness. A progress note dated August 12, 2015 notes improvement of the right hand after a stellate ganglion block. The physical exam dated June 15, 2015 reveals right hand edema, slight erythema with blanching appearance, waxy characteristic to the skin, exquisite tenderness over the thumb and first digit, and loss of supination of -90 degrees. The progress note dated August 12, 2015 documented a physical examination that showed less edema of the right hand, skin no longer shiny and taut, and now able to flex fingers slowly. Treatment has included at least twenty four sessions of occupational therapy, medications (Norco, Neurontin, Hydrocodone and Celebrex since at least June of 2015), and stellate-ganglion block on August 4, 2015 with improvement of the right hand. The treating physician indicated that the injured worker required therapy for aggressive desensitization to try to head off the reflex sympathetic dystrophy. The original utilization review (August 20, 2015) non-certified a request for eighteen sessions of occupational therapy for the right upper extremity.

IMR ISSUES, DECISIONS AND RATIONALES

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

18 Occupational Therapy Sessions, 2-3 Times a Week for 6 Weeks, Right Upper Extremity:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, wrist, and hand section, Physical therapy.

Decision rationale: Pursuant and to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, 18 occupational therapy sessions 2 to 3 times per week for six weeks, right upper extremity is not medically necessary. Patients should be formally assessed after a six visit clinical trial to see if the patient is moving in a positive direction, no direction or negative direction (prior to continuing with physical therapy). When treatment duration and/or number of visits exceed the guideline, exceptional factors should be noted. In this case, the injured workers working diagnoses are open reduction internal fixation mid shaft radius and ulna; recent development reflects sympathetic dystrophy in the right hand; and right radioulnar synostosis proximately. Date of injury is September 18, 2014. Request for authorization is August 13, 2015. The medical record contains 19 pages. According to a June 15, 2015 progress note, the injured worker received 24 prior occupational therapy sessions. There are no occupational therapy progress notes in the medical record. The documentation indicates the injured worker may have developed possible reflex sympathetic dystrophy in 2015. Subjectively, medications include Norco and Neurontin with the pain score of 7/10. Objectively, the right hand is edematous with erythema. There is tenderness to palpation at the first digit with decreased range of motion. As noted above, the injured worker received 24 prior occupational therapy sessions. The injured worker should be well-versed in a home exercise program. There are no compelling clinical facts in the medical record to support additional physical therapy over and above the recommended guidelines. As noted above, there are no prior physical/occupational therapy progress notes. Based on the clinical information in the medical records, peer-reviewed evidence-based guidelines, no documentation demonstrating objective functional improvement from prior occupational therapy and no compelling clinical facts indicating additional occupational therapy as clinically indicated in the 19 page medical record, 18 occupational therapy sessions 2 to 3 times per week for six weeks, right upper extremity are not medically necessary.