

Case Number:	CM15-0216802		
Date Assigned:	11/06/2015	Date of Injury:	02/10/2015
Decision Date:	12/18/2015	UR Denial Date:	10/28/2015
Priority:	Standard	Application Received:	11/03/2015

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:

This 58 year old male sustained an industrial injury on 2-10-15. Documentation indicated that the injured worker was receiving treatment for a right distal radial fracture. Previous treatment included open reduction internal fixation right wrist (2-13-15). The injured worker received postoperative occupational therapy and medications. In an occupational therapy evaluation dated 8-25-15, the injured worker complained of pain during rest, rated 4 to 5 out of 10 on the visual analog scale and pain during use rated 5 to 6 out of 10, despite recent cortisone injections. The occupational therapy noted moderate swelling within the fingers and forearm. Active range of motion was limited by swelling, joint tightness and possible tendon or muscle shortening. Grip and grasp were diminished. Significant scar adhesions remained. The occupational therapist noted that the injured worker's participation in daily activities involving a resistive grasp, forearm circumduction or reaching overhead were limited. In an occupational therapy progress note dated 9-25-15, the injured worker complained of pain at rest, rated 1 to 2 and pain during use rated 5 to 6 out of 10. The occupational therapist noted persistent swelling of the entire hand. The injured worker was unable to form a solid composite fist and had pain during finger flexion and release of sustained grasp. The injured worker could pull doors and grip and turn shower handles. In a progress note dated 10-12-15, the injured worker complained of ongoing pain, weakness and stiffness in his right hand and wrist. The physician documented that computed tomography of the right upper extremity (9-21-15) showed a healed fracture of the distal right radius internally fixed with surgical hardware and a small un-united fracture of the ulnar styloid process. The physician's impression was "resolving wrist and digital stiffness".

No physical exam was documented. The injured worker had completed 36 sessions of occupational therapy. The treatment plan included occupational therapy twice a week for six weeks. On 10-28-15, Utilization Review non-certified a request for occupational therapy twice a week for six weeks for the right wrist.

IMR ISSUES, DECISIONS AND RATIONALES

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

Occupational therapy (OT) 2 times per week for 6 weeks to the right wrist: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

Decision rationale: Review indicates the patient is s/p ORIF of the right wrist on 2/13/15 with at least 36 therapy sessions rendered now beyond postsurgical rehab with Chronic Treatment guidelines applicable. Occupational therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified occupational therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. However, there is no clear measurable evidence of progress with the OT treatment already rendered including milestones of increased ROM, strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints, clinical findings, and functional status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. The Chronic Pain Guidelines allow for 9-10 visits of occupational therapy with fading of treatment to an independent self-directed home program. It appears the employee has received significant therapy sessions without demonstrated evidence of functional improvement to allow for additional therapy treatments. There is no report of acute flare-up, new injuries, or change in symptom or clinical findings to support for formal OT in a patient that should have been instructed on a home exercise program for this chronic injury. Submitted reports have not adequately demonstrated the indication to support further occupational therapy when prior treatment rendered has not resulted in any functional benefit. The Occupational therapy (OT) 2 times per week for 6 weeks to the right wrist is not medically necessary and appropriate.