

Case Number:	CM15-0083419		
Date Assigned:	05/05/2015	Date of Injury:	01/12/2012
Decision Date:	06/04/2015	UR Denial Date:	04/29/2015
Priority:	Standard	Application Received:	04/30/2015

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 51 year old male who sustained an industrial injury on 01/12/12. Initial complaints and diagnoses are not addressed. Treatments to date include occupational therapy, 19 visits preoperatively, and an additional 32 visits postoperatively. He underwent triangular fibrocartilage repair (TFCC) on 09/30/14. Diagnostic studies include a MRI Arthrogram and Arthrogram of the right wrist. Current complaints include continued pain. Current diagnoses include status post right TFCC repair and right cubital and carpal tunnel releases. In a progress note dated 03/04/15 the treating provider reports the plan of care as modified duty with a 1-pound restriction on the right side and continued strengthening regimen. The requested treatment is additional occupational therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional occupational therapy, right wrist (8 sessions): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Therapy, pages 98-99.

Decision rationale: 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 has 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 Additional occupational therapy, right wrist (8 sessions) is not medically necessary and appropriate.