

Case Number:	CM15-0117314		
Date Assigned:	06/25/2015	Date of Injury:	11/21/2013
Decision Date:	07/27/2015	UR Denial Date:	05/13/2015
Priority:	Standard	Application Received:	06/17/2015

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: Connecticut, California, Virginia
 Certification(s)/Specialty: Preventive Medicine, Occupational 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:

The injured worker is a 59-year-old female who sustained an industrial injury on 11/21/2013 resulting in left elbow and wrist pain. She is diagnosed with lateral epicondylitis of the left elbow, cubital tunnel syndrome of the left elbow, and deQuervain's stenosing tenosynovitis of the left wrist. Treatment has included use of stabilizing brace, oral and topical medication, cortisone injections to the elbow, physical therapy, and acupuncture, but the injured worker reported minimal relief of pain and functioning from these interventions. She reports some improvement with use of ice. The injured worker continues to report activity-dependent stiffness, and constant dull, radiating pain. The treating physician's plan of care includes an activities of daily living evaluation. She is temporarily totally disabled and not working.

IMR ISSUES, DECISIONS AND RATIONALES

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

ADL-date of service 11-10-14: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines(ODG).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter, home health services.

Decision rationale: The MTUS does not address evaluation of ability to complete activities of daily living, and therefore the ODG provides the preferred mechanism of assessing medical necessity in this case. According to the ODG pain chapter, section on home health services, evaluation of the medical necessity of home health care services is made on a case-by-case basis, an assessment that includes evaluation of activities of daily living. In this case, the patient has left upper extremity symptoms but is noted to be right-hand dominant. The provided records do not show evidence of deficits concerning for activities of daily living at a level warranting evaluation in the opinion of this medical reviewer. Therefore, without further explanation for the need to evaluate ADLs in what appears to be fairly minimal pain/discomfort in the non-dominant upper extremity, the request is not considered medically necessary.