

Case Number:	CM15-0064983		
Date Assigned:	04/13/2015	Date of Injury:	07/23/2014
Decision Date:	06/11/2015	UR Denial Date:	03/25/2015
Priority:	Standard	Application Received:	04/06/2015

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: Maryland

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Neuromuscular 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 53 year old female, who sustained an industrial injury on 7/23/14. She reported a right wrist injury. The injured worker was diagnosed as having status post right distal radius fracture with external fixator replacement and CRPS. Treatment to date has included external fixation of right wrist fracture, physical therapy and oral medications. Currently, the injured worker complains of right wrist pain. Physical exam noted decreased range of motion of right wrist with mild tenderness across the distal palm. The treatment plan included oral medications including Voltaren, Protonix and Ultram, pain management, occupational therapy and follow up appointment.

IMR ISSUES, DECISIONS AND RATIONALES

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

Occupational Therapy 3 Times A Week for 4 Weeks Right Upper Extremity: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98-99.

Decision rationale: Occupational therapy 3 times a week for 4 weeks right upper extremity is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The request exceeds the recommended number of visits for this condition per the MTUS. The 3/17/15 document states that she has right wrist pain, radiation to the shoulder and coldness, numbness, tightness. The request as written exceeds guideline physical medicine recommendations for these symptoms. The request is not specific as to whether the therapy is to a particular body part as the patient has already had some therapy on her right wrist. Furthermore, the recent April 2015 documentation suggests possible radicular symptoms, which would not necessitate therapy for the right upper extremity. For all of these reasons the request for occupational therapy for the right upper extremity is not medically necessary.