MAXIMUS Federal Services

Case Number:	CM15-0070139		
Date Assigned:	04/17/2015	Date of Injury:	12/08/2014
Decision Date:	05/18/2015	UR Denial Date:	04/02/2015
Priority:	Standard	Application Received:	04/13/2015

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: Iowa, Illinois, Hawaii
Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive 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 was a 21 year old female, who sustained an industrial injury, December 8, 2014. The injured worker was grasping a piece of paper and pulling it with the right hand and fingers when the injured worker felt a pulling sensation in the right wrist. The injured worker developed a lump on the right wrist with increased numbness in the right hand. The injured worker previously received the following treatments 12 physical therapy, right wrist x-rays, right wrist brace, Ibuprofen and Tylenol #3. The injured worker was diagnosed with radial styloid tenosynovitis of the right wrist and carpal tunnel syndrome (median nerve entrapment at the right wrist). According to progress note of February 5, 2015, the injured workers chief complaint was right wrist thumb and hand pain. The injured worker described the pain as intermittent moderate pain and aching. The pain was aggravated by gripping and lifting heavy items. The physical exam noted the Tinel's teat was positive on the right. Phalen's and Finkelstein's tests were positive. The right Jamar Dynamometer readings were 6/8/6 and the injured worker was right hand dominant. The treatment plan included work hardening program 10 visits for the right wrist.

IMR ISSUES, DECISIONS AND RATIONALES

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

Work Hardening for the right wrists, ten visits: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Work Conditioning, Work Hardening Page(s): 125.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Work conditioning/work hardening Page(s): 125-126. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist and Hand (Acute & Chronic), Work conditioning/work hardening.

Decision rationale: Chronic Pain Medical Treatment Guidelines state regarding work condition/hardening: (1) Work related musculoskeletal condition with functional limitations precluding ability to safely achieve current job demands, which are in the medium or higher demand level (i.e., not clerical/sedentary work). An FCE may be required showing consistent results with maximal effort, demonstrating capacities below an employer verified physical demands analysis (PDA). (2) After treatment with an adequate trial of physical or occupational therapy with improvement followed by plateau, but not likely to benefit from continued physical or occupational therapy, or general conditioning. (3) Not a candidate where surgery or other treatments would clearly be warranted to improve function. (4) Physical and medical recovery sufficient to allow for progressive reactivation and participation for a minimum of 4 hours a day for three to five days a week. (5) A defined return to work goal agreed to by the employer & employee: (a) A documented specific job to return to with job demands that exceed abilities, OR (b) Documented on-the-job training (6) The worker must be able to benefit from the program (functional and psychological limitations that are likely to improve with the program). Approval of these programs should require a screening progress that includes file review, interview and testing to determine likelihood of success in the program. (7) The worker must be no more than 2 years past date of injury. Workers that have not returned to work by two years post injury may not benefit. (8) Program timelines: Work Hardening Programs should be completed in 4 weeks consecutively or less. (9) Treatment is not supported for longer than 1-2 weeks without evidence of patient compliance and demonstrated significant gains as documented by subjective and objective gains and measurable improvement in functional abilities. (10) Upon completion of a rehabilitation program (e.g. work hardening, work conditioning, outpatient medical rehabilitation) neither re-enrollment in nor repetition of the same or similar rehabilitation program is medically warranted for the same condition or injury. The medical documentation provided did not adequately address the Chronic Pain Medical Treatment Guidelines for work conditioning programs. Mainly "After treatment with an adequate trial of physical or occupational therapy with improvement followed by plateau, but not likely to benefit from continued physical or occupational therapy, or general conditioning", "defined return to work goal agreed to by the employer & employee." As such, the request for Work Hardening for the right wrists, ten visits is not medically necessary.